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ABSTRACT

The practicum was designed to assist parents of head-injured children in dealing with the special education system. The program provided parents with information about the special education system and encouraged them to take an active role at the Individualized Education Program (IEP) conference. Parents were also helped to better understand the changes in their head-injured child. Interviews with 28 parents of head-injured children revealed that parents were not being active participants at their child's IEP meeting. Feelings of stress, lack of knowledge about the purpose of an IEP, and negative feedback from school personnel were causes most often cited by parents for their passive role. Parent training sessions were designed and implemented to teach parents about: Public Law 94-142, the Education for All Handicapped Children Act; neuropsychological assessments; cognitive impairments; sensory and perceptual difficulties; social and emotional difficulties; and IEPs. Results of the practicum were positive. The program increased the parents' knowledge and understanding about the educational needs of their head-injured child. (Author/DB)

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PARENT EDUCATION TO IMPROVE PARENTAL INVOLVEMENT IN IEP'S FOR SEVERELY HEAD-INJURED CHILDREN IN GRADES 1-12

by

Sidney L. Payne

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NOVA UNIVERSITY

PARENT EDUCATION TO IMPROVE PARENTAL INVOLVEMENT IN IEP'S FOR SEVERELY HEAD-INJURED CHILDREN IN GRADES 1-12.

by

Sidney L. Payne

Cluster XXIII

A Practicum I Report Presented to the Ed.D. Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

Nova University

1988

OCT 6 1988

PRACTICUM APPROVAL SHEET

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8-24-88

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Advisor

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ABSTRACT

Parent Education to Improve Parental Involvement in IEP'S for Severely Head-Injured Children in Grades 1-12.

Payne, Sidney L., 1988: Practicum Report, Nova University Ed.D. Program in Early and Middle Childhood.
Descriptors: Head Injury / Traumatic Brain Injury / Pediatric Head Injury / Severe Closed Head Injury / Parent Education / Parent Training / Parent Involvement / Parent Attitudes / Parent School Relationship / IEP Conferences

This practicum was designed to assist parents of head-injured children in dealing with the special education system. The primary goal was to provide parents with information about the special education system, to understand the importance of taking an active role at the IEP conference, and to ease parent apprehensions about working with the multidisciplinary team. A second aim was to help parents better understand the changes that have taken place in their head-injured child.

Interviews with 28 parents of head-injured children revealed that parents were not being active participants at their child's IEP meeting. Feelings of stress, lack of knowledge about the purpose of an IEP, and negative feedback from school personnel were causes most often cited by parents for their passive involvement.

The writer designed and implemented parent training sessions on Public Law 94-142, neuropsychological assessments, cognitive impairments, sensory and perceptual difficulties, social and emotional difficulties, and IEP's. The results of the practicum were positive. The overall program increased the parents' knowledge and understanding about the educational needs of their head-injured child.

Chapter I

INTRODUCTION

Description of Community

The community in which the practicum took place is a resort community in southwestern United States. It is often referred to as "The Entertainment Capital of the World" and claims the largest resort hotels in the world. A growing tourist and convention industry, along with new manufacturing industries, has resulted in the population doubling over the last ten years. Today there are over half a million residents. It is the largest city in the state.

Besides the resorts the community is home to one of the two state universities. This university has one of the most superior hotel colleges in the United States and as a result attracts students from the entire country. The university is the center of the residential community and provides residents with an Allied Arts Council, symphony orchestra, a professional ballet company and one of the country's top rated basketball teams.

The socioeconomic make-up of the community runs the gamut. Like any major metropolitan city there are areas of extreme poverty as well as great affluence. However, the majority of the community would be considered middle class. Because it is a resort community the population is more transient than most communities.

Writer's Work Setting and Role

The school in which the practicum was conducted is a public school for special education. Since it's establishment 35 years ago, the student body has grown from 14 students to 354; and the staff, from 7 to 141. This growth has necessitated the establishment of two separate campuses a mile and a half apart. The ethnic make-up of the school reflects that of the community. The student population is significantly weighted in regard to male/female ratio as is usually the case in special education.

The school is home to eight different programs: 1) diversely handicapped preschool, 2) diversely handicapped kindergarten, 3) multiple handicapped, 4) physically handicapped, 5) communication behavior disordered, 6) severely communication impaired, 7) severely multiple handicapped, 8) post secondary program, 9) homebound program. The diversely handicapped preschool and severely multiple handicapped programs are on one campus with the remainder of the programs being served on the other campus. As a result of the diverse population being served the related services available include speech therapy, occupational therapy, physical therapy, adaptive physical education, and transportation.

The philosophy of the school incorporates the precepts

of excellence in education. Each child's potential is developed in an atmosphere which considers the total child. A variety of services are provided to maximize the educational experience. Programs are often a transitory step in preparing the student for education in the home school. This facilitates the concept of least restrictive environment required by law.

Classroom placement is determined on the basis of test scores and the recommendations of the multidisciplinary team. No decision concerning change of placement or programming is considered without a mutual consultation with team members. All students receive adaptive physical education, swimming, library, and music in addition to academic programming in an effort to provide a well-rounded educational experience.

The administration consists of one principal, one assistant principal and a program consultant. The office of the assistant principal is housed on the campus with the diversely handicapped preschool and the severely multiple handicapped programs. All three administrators hold teaching certificates in special education and have taught in the field of special education.

The faculty is composed of 141 full time positions which include:

1. 45 certified special education teachers
2. 47 classroom assistants
3. 2 adaptive physical education teachers

4. 3 speech therapists, 1 assistant
5. 2 occupational therapists, 1 assistant
6. 2 physical therapists, 3 assistants
7. 1 swimming instructor, 1 assistant
8. 1 music therapist
9. 1 librarian, 1 assistant
10. 1 school psychologist
11. 1 nurse, 2 assistants
12. 1 vocational counselor, 1 assistant
13. 1 homebound coordinator
14. 6 homebound teachers
15. 1 family assistant aide
16. 4 secretaries
17. 3 kitchen staff
18. 8 custodians
19. 3 administrators

Of the 141 staff members, 21 are males, two of which are administrators.

Five of the staff members are handicapped. The principal has degenerative arthritis and requires a wheelchair at times for ambulation. The adaptive physical education assistant is a paraplegic and is confined to a wheelchair. The three other staff members are ambulatory; a classroom teacher has moderate cerebral palsy, a physical therapy assistant has rheumatoid arthritis, and a classroom assistant has dystonia.

Although the school is a public school it was

originally founded by a private organization and opened its doors in December, 1952. In September of 1953, the organization turned the school over to the school district with a pledge of continued support. Over the years the organization has added many structural additions which include electric entrance doors and a natatorium. They have also presented the school with several lift buses, funding for equipment and specialized programs. By the end of this year each classroom will be equipped with at least one Apple computer. The goal of this organization to make the school second to none has resulted in this school being one of the best equipped special schools in the country.

The writer's background has been deeply imbedded in developmental education. The writer holds an undergraduate degree in psychology and a master's degree in special education. The writer is certified by the Department of Education in the following areas: 1) mild to moderate mental handicaps, emotional handicaps, and learning disabilities K-12 2) physical handicaps k-12, 3) secondary education in psychology, 4) substitute in regular education K-12, and 5) substitute in all areas of special education K-12.

The writer has taught in the present school for the past six years, three years as a substitute and three years in the present position as classroom teacher for ten physically handicapped children ranging in age from 13 to 18. All students are within the normal range of

intelligence and have physical handicaps so severe that they cannot be maintained within a regular classroom. All students receive physical therapy on a regular basis during the course of the school day.

Of the ten children in the classroom eight are in wheelchairs and two are ambulatory, one of which uses an lofstrand crutches. Three students have head injuries as a result of accidents, four students have severe cerebral palsy, one student has leukemia, one student has spina bifida, and one student has Batten's disease. Batten's disease is a juvenile form of amaurotic family idiocy which results in a premature death.

The classroom is self-contained with the writer responsible for all academic programming. There is one full-time classroom assistant, a 4 hour a week part-time assistance who works with a non-oral accident victim on computer assisted communication, and a morning foster grandparent. A 40 minute geography is the only subject taught as a class. All other instruction is in small groups or direct one-on-one instruction. The writer was yearbook advisor for the past two years and assisted this classroom in producing two outstanding yearbooks.

The writer has also been an extremely active volunteer in community and professional organizations serving disabled children and adults for the past fifteen years. The writer presently holds the office of president for the local head trauma support group, is secretary of the local chapter of

The Council for Exceptional Children, serves as a consultant for the Muscular Dystrophy Association, is a member of the planning board for the local Association for the Handicapped committee on independent living, and is an executive board member for the local Computer and Technology Center for Disabled Children and Adults.

In the past the writer has been honored by the governor for many hours of volunteer service to mentally handicapped children. The writer has also been honored by the Muscular Dystrophy Association as an outstanding activity coordinator at the regional summer camp for two consecutive years. Recognition was recently given to the writer by the local chapter of The Council for Exceptional Children for excellence in publishing their newsletter. The writer's most cherished recognition came last year when acknowledgement was expressed by The Special Education Parent Advisory Committee for Excellence in Education.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The educational needs of severely head-injured children are being addressed by the multidisciplinary team at the writer's school as mandated by Public Law 94-142. Needs of these students are continually assessed by the team and programs are frequently updated. By law, parents are to be an important part of this team. However, parents at this school are passive members of the team. They sit in bewilderment as professionals spout their technical terminology and theoretical rational for the proposed programming. Often the only active role these parents play is signing their name on the bottom line after the professionals on the team have assured them that they know what is best for their child.

These parents are dealing with special education for the first time and are having difficulty adjusting, not only to the many changes in their child, but the changes in educational procedures as well. They are not accustomed to playing an active role in determining what programming and instructional techniques are best for their child, because regular education never made these demands. These parents do not realize that they are a vital member of the multidisciplinary team. Knowledge of their child's permorbid capabilities is crucial to programming. Parents

appear to feel their contributions are insignificant compared to the technical expertise of the professional team members. They are intimidated to the point where they sit quietly in the background while others take charge of their child's future.

This does not mean that these parents are not "partners in education" at this school. They are welcomed with open arms and encouraged to become active members of the parent teacher organization and to get involved with school activities. Their assistance is often requested in fund-raising efforts, advocacy issues, or public relations for the handicapped. Like parents of many school-aged children they bake cookies for parties and provide transportation for field trips. The one thing these parents are not actively involved in or encouraged to become actively involved in is the educational program for the rehabilitation of their child.

The problem that will be addressed by this practicum is the passive involvement of parents of severely head-injured children in their child's educational programming.

Problem Documentation

A review of the records of the local head trauma support group, of which the writer is president, revealed the names of 28 school age children who have suffered a severe head injury and are presently in special education

classes. These parents were all contacted by phone and asked to answer eight questions (Appendix A) about their child in relation to the education they are receiving. All 28 parents participated.

Results of the interviews (Appendix B) verified the writer's available records. All 28 children suffered "severe" head injuries, and are presently being served in the local special education system. The average age in this group of children was 12.9 years.

Analysis of the interviews revealed that the majority of parents attend their child's IEP conferences. Only one parent states that he never attended the conferences. Twenty-six of the parents attended their child's last IEP conference.

The most significant information to be brought to light with this interview was the recognition that all 28 parents stated that they do NOT look forward to IEP conferences. Twenty-five of the twenty-eight voiced that stress and anxiety were the major factors causing their apprehension. Sixteen parents stated that they did not see the purpose of their attendance when the teachers have all the decisions made before they arrive. Thirteen parents felt the teachers were extremely negative about their child. Six stated clearly that they just do not like the school or the administration. Six stated that the conferences were at inconvenient times. One angry parent stated emphatically that the school hated his child.

When asked if they would like to play a more active role in their child's educational program, twenty-one of the parents responded affirmatively. Recommendations for assisting them to become more involved were many. Eighteen of the parents voiced that they really did not understand the purpose of the IEP and would like to have someone take the time to explain. Sixteen parents stated they really did not know their roles and would appreciate clarification of their responsibilities. Sixteen parents felt that they needed assistance in understanding the terminology used in the conference. Fifteen stated they would appreciate more information on head injuries and their long term affects. Twelve parents stated that they would appreciate knowing the alternatives to not keeping their child in a special school or special classes. Eight parents were concerned about the test results and recommended someone take the time to really explain the purpose of each test and what the scores really mean. One parent stated that there was nothing the school could do for him or his child.

Causative Analysis

The passive involvement of parents of severely head injured children in the educational programming of their child is believed, by the writer, to have many causes. Perhaps the most important cause is that these parents are

having to come to grips with their shattered dreams. Seeing their child return to school only to enter a "special" classroom is one more disappointment. Coping with the loss of a child, as he or she was once known, is often all that a parent can handle at one time. Having to come face to face and be a part of the special education system is just another reminder of life's cruelty.

Another major cause is a lack of knowledge by the parent of the special education system. These parents, although often involved in school related activities, have never had to actually participate in designing an educational program and make decisions about that program. In the regular school, all children follow the same curriculum which is set by the school district. Often these parents are just not aware of their responsibilities under P.L. 94-142.

A third cause is that these parents often feel intimidated by the professionals and their use of foreign terminology and theoretical approaches to problem solving. A parent, sitting amidst a group of professionals, often feels as though there is little that they can contribute. They do not realize that they are a vital link to their child's recovery. They have knowledge and insights about their child which will not be uncovered in the multitude of assessment instruments that will be administered to their child. They are unaware that these insights are often the key to success in working with their child.

A fourth cause is that some members of the staff do not realize that these parents are not aware of their responsibilities and that they do not understand much of the terminology. The staff at this school is accustomed to working with parents who have had their children in special education from the beginning of their education and who are "old hats" at the system. They take it for granted that these parents are familiar with all the forms, terminology, and assessment techniques used on their child.

Another serious cause is that many of the professionals on the team really do not want parent involvement. It takes extra time to deal with parents, especially parents who are new to the system and are still showing signs of nonacceptance. Not only do these parents know nothing about how the special education system works, but they know little about head trauma rehabilitation. Many of the staff members feel that parents are more of a burden than a vital link to the recovery process and would prefer that these parents be passive members of the team.

Related Literature

Shea and Bauer (1985) suggest that the success of the U.S. Educational system may have unwittingly alienated many parents and teachers from each other. In recent decades the quantity and complexity of knowledge has surged dramatically, making it difficult for many parents to master

the information or skills they need to help their children succeed in school and function successfully in modern society.

A review of the literature revealed that the lack of parent involvement in their child's special education program may have several causes. These causes fall into five distinct areas: 1) parents having difficulties coping with the injury of their child, 2) parents feeling inadequate in the presence of professionals, 3) parents not knowing their rights and responsibilities concerning special education, 4) professionals not understanding the needs of these parents and, 5) professionals actually discouraging parental involvement.

Provisions for parental involvement in the education of their handicapped child has been provided with the passage of P.L. 94-142, The Education for All Handicapped Children Act. Recent research, however, has indicated that often parents are not active decision-makers in the development of the individualized education program (Gilliam 1979; Goldstein, Strickland, Turnbull, & Curry, 1980).

Severe head injury has a devastating impact on the parent as well as on the child (Ylvisaker, 1985). Initially parents face the shock of having the life of their previously healthy child hanging by a thread. Once they know that the child will live, they begin to receive frightening warnings about the changes in their child. When they press for answers concerning their child's educational

prognosis, the replies are always uncertain.

When parents become aware of their child's exceptionality, they are inevitably shocked. They must suddenly adjust to the loss of their child as they knew him or her. Hutzler (1980) states that this loss is as real as if the child had died, yet it is more complex. The child that they once knew is gone and a stranger somehow inhabits the body they have watched grow since birth. The personality that they had nurtured is also altered, perhaps beyond recognition. These parents pass through the grieving process that involves shock, anxiety and helplessness, denial, guilt, anger, and depression (Poliniko, Barin, Leger, & Bauchman, 1985).

Each parent reacts to a child's injury uniquely, depending on their personal characteristics, life experiences, education, training, expectations, cultural background, and personal, social, and economic resources (Chin, Winn, and Walter, 1978). Moreover, parents' reactions may vary according to the degree of their child's handicap and the importance they place on having a normal child (Hoff, 1978).

The stresses involved in accepting their child as handicapped often influences the parents' level of involvement in their child's educational programming (MacMillan and Turnbull, 1983). The more severe the child's disability, the greater the demands on the parents. For some parents, the school day is their only respite, so they

seek to stay uninvolved.

Shea and Bauer (1985) suggest that often parents are unwilling to accept that their child is exceptional and in need of special education services. These parents stay uninvolved out of a sense of denial.

Many parents are uninvolved in their child's educational programming because they feel inadequate in the presence of people from the medical or educational professions. They are embarrassed to ask questions when they hear terminology that is foreign to them (Smith, 1984). Parents may feel threatened by professionals. They often feel dominated by these professionals and worry about saying something stupid or doing something improper.

On the other hand, parents who are familiar with procedures and terminology often have to deal with condescension from professionals who assume that "nonprofessionals" do not understand (Muir-Hutchinson, 1987).

Berger (1987) suggests that debilitating experiences with schools, feelings of inadequacy, poor achievement by children and pressures of the present can cause some parents to stay away from the school. These parents had negative experiences with schools before their child's injury and feel these experiences will not change just because their child has changed.

The teacher's role is central to parental involvement in the educational process. It is the classroom teacher who

usually has constant contact with the parent. If this relationship does not result in making the parent feel comfortable and important, the parent will not become involved (Berger, 1985).

Oversimplification of parenting advice is another problem that often results in uninvolvement of parents. Parents receive instructions on how to best serve their child. The experts' messages are clear (Shea & Bauer, 1985). If parents follow their formulations, their child will mature. When these formulations do not work, parents feel like failures.

It was noted by Lombana (1982) that parents often complain that a major problem hampering involvement of parents in school relationships is that involvement strategies are generally designed to suit the needs of school personnel, without regard to the needs of the parent.

Many parents are not involved because they are just not aware of their responsibilities under P.L. 94-142 (Berger, 1987). Parents have rights as well as responsibilities in the implementation of P.L. 94-142. They must be notified and permission obtained for special programs. Often these parents are told their rights but are not aware of their responsibilities.

A lack of understanding from the professionals about the social-emotional needs of the parents was noted by Muir-Hutchinson (1987), a parent of an exceptional child. This parent wrote about the need for sensitive and practical

assistance in acting as a child's prime therapist. Muir-Hutchinson described the frustration when professionals in school, clinic, and community agencies failed to offer assistance and understanding, and pointed to a need for better professional training and greater sensitivity.

Lack of involvement is often a result of subtle messages that parents receive from the schools and the professionals. Educators do not universally agree that parents should be a part of their child's education. Simpson (1982) suggests that some educators incorrectly believe that educational decisions are solely their domain and are not to be shared with parents. He also found that some educators believe that parents cause many of their children's problems and are in need of help themselves.

Shevin (1983) stated that too often professionals focus more on obtaining parents' signatures on the appropriate line, by the correct date, than on encouraging them to participate fully in decision making for their children.

Professionals continue to use their jargon and technical terminology, thus inhibiting communication. Schuck (1979) noted that educators are often unable or unwilling to use jargon-free language.

Morrison (1978) suggests that a lack of real effort on the part of most schools to include parents and a lack of enthusiasm on the part of the teachers and other educators towards parent involvement keep parents from participating.

In a detailed discussion of parent involvement, McAfee

and Vergason (1979) noted that many professionals do not recognize parents as the most important influence on their child's development.

Findings by Yoshida, Fenton, Kaufman, and Maxwell (1978) support other researchers' work on professionals' views of parent involvement. In 1976, they surveyed 1,526 placement and program planning team members in Connecticut on their view of parents' appropriate role on their children's educational planning team. Analysis of the 1,372 questionnaires indicated that over half the respondents selected only two appropriate activities for parents: presenting information relevant to the case and gathering information relevant to the case. In some areas in which legal and legislative initiatives have increased parent participation, affirmative responses were few. The researchers concluded that the professional members of the planning team expected parents to provide information but not to participate in decision making about their exceptional child's program. In turn, they suggested the professionals' attitudes help determine the actual role parents assume during team meetings.

In conclusion, the problem is not one that can be easily solved. The dynamics involved in the needs of special children and their families are great. Collaborative relationships are dependent on the positive contributions of both parties. From this perspective, when parent-professional relationships are poor one can assume

that both parties contribute to the situation.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Statement of General Goals

Having parents involved in the educational planning of their head-injured child is beneficial to both the child and the parent. Due to the nature of head injuries it is extremely important that programming at school and at home follow the same guidelines. Without parental involvement this type of continuity cannot be obtained. The writer's goals were to provide parents with information about the special education system and to ease their apprehensions about working with the multidisciplinary team. The writer's second goal was to help the parents better understand the changes that have taken place in their child and assist them in their goal to have their child reach maximum potential physically, educationally, and emotionally.

Behavioral Expectations

Objective One

Over a period of 12 weeks parents will demonstrate an increased knowledge of Public Law 94-142 by responding correctly to 8 out of 10 items on a questionnaire developed by the writer (Appendix C).

Objective Two

Over a period of 12 weeks parents will demonstrate an

increased knowledge and understanding of the assessment instruments used to evaluate head-injured children by responding correctly to 8 out of 10 items on a questionnaire developed by the writer (Appendix D).

Objective Three

Over a period of 12 weeks parents will demonstrate an increased knowledge and understanding of cognitive disorders of head-injured children by responding correctly to 8 out of 10 items on a questionnaire developed by the writer (Appendix E).

Objective Four

Over a period of 12 weeks parents will demonstrate an increased knowledge and awareness of sensory and perceptual motor difficulties of head-injured children by responding correctly to 8 out of 10 items on a questionnaire developed by the writer (Appendix F).

Objective Five

Over a period of 12 weeks parents will demonstrate an increased knowledge and awareness of social and behavioral difficulties of head-injured children by responding correctly to 8 out of 10 items on a questionnaire developed by the writer (Appendix G).

Objective Six

Over a period of 12 weeks parents will demonstrate an increased knowledge of the IEP process by responding correctly to 8 out of 10 items on a questionnaire developed by the writer (Appendix H).

Evaluation Instruments

Objective one was measured by a teacher-made questionnaire entitled "Public Law 94-142" (Appendix C). The measure was made up of 10 true-false and multiple choice items.

Objective two was measured by a teacher-made questionnaire entitled "Neuropsychological Assessments" (Appendix D). This measure was made up of 10 true-false items.

Objectives three, four, and five were measured by teacher-made questionnaires entitled "Cognitive Impairments" (Appendix E), "Sensory and Perceptual Motor Difficulties" (Appendix F), and "Social and Emotional Difficulties Following Head Injury" (Appendix G). These 10 item questionnaires required the parent to match terminology to the example of behavior. These assessment devices were designed to provide parents with practical application experiences involving new terminology.

Objective six was measured by a teacher-made questionnaire entitled "Individual Education Programs" (Appendix H). This 10 item questionnaire required the parent to circle the best answer or fill in the blank.

MECHANISM FOR RECORDING UNEXPECTED EVENTS

Due to the extended length of time this project covered,

provisions were made to monitor unexpected events. The writer kept a bi-weekly log (Appendix I) to record these events. The journal noted what was working well and what was not working well. The journal also contained comments from parents as well as other staff members working with these parents.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation Of Possible Solutions

Educators have begun to study the effectiveness of different strategies that can be employed to increase parent participation. Brainstorming and a review of the literature exposed several possible solutions. Since parent involvement requires the home and the school to work together, the solution strategies are two fold. One procedure revealed was to provide parents with education, training, and support, while the other employs methods to make professionals more sensitive to the needs of these special parents.

The school district in which the writer works has mandated that a teaching certificate cannot be renewed without a course in parent education. This district is aware of the need for improved home-school relationships and is attempting a solution. However, the unique needs of parents of head-injured students have not been addressed.

Kroth (1985) recognizes the importance of parental involvement in programs for exceptional children and suggests that educators make contact with the parent before the placement of a child in their classroom. Kroth feels that this conference will establish a rapport necessary for future cooperative efforts. Such preliminary contacts have

been shown to be closely correlated with the educational growth of children.

The writer feels that this suggestion is excellent. At the writer's school the first contact with a new parent is at the IEP meeting which was arranged through the mail. A preliminary conference with the parent to make them feel comfortable and to answer their questions before a formal IEP meeting could prove to be quite beneficial.

Goldstein and Turnbull (1982), in a study of involvement of parent participation in IEP conferences, concluded that parents who were provided with a specially trained advocate during the conference assumed a greater degree of involvement. Advocates were trained to ask the first few questions at the conference, and as a result, parents began to ask questions or comment on what they saw their child doing at home. The advocates also introduced the parent at the conference, directed questions to them, verbally reinforced their contributions, and summarized the discussion at the end of the conference.

Another solution strategy researched by Goldstein and Turnbull to improve parent involvement in IEP conferences was sending questions to parents before the conference. Although the groups of parents who received questions prior to the conference did not contribute significantly more to the IEP conference than the control group, a post hoc analysis indicated that a significantly larger proportions of fathers who had received questions attended conferences.

It was conjectured that the fathers perceived the conference as important to their child's education after reviewing the questions. Another possible explanation is that parents receiving questions requested their spouses' participation and support, feeling that they might be outnumbered by professionals at the conference.

Both ideas of Goldstein and Turnbull could be utilized to increase parent involvement and could be implemented within the writer's works setting without difficulty. In the writer's work setting advocates are usually recommended only when there is a disagreement between the parent and the school. Bringing in an advocate to avoid reaching disagreements and to make the parent feel comfortable is far more appropriate. If questions were sent to the parent before the IEP meeting, the advocate could assist the parent and help prepare them for the upcoming meeting.

Ron Savage (1985), director of education for the National Head Injury Foundation, feels it is the responsibility of the parent to make sure that they are involved in the educational process. Savage feels that professionals may not be encouraging parents to participate because they are not educated in the needs of head-injured children or their families. Savage suggests that parents take the dominant role and set up a training session to in-service the staff on head injuries, the needs of their child, and the needs of the family.

The writer is in disagreement with Savage on his

solution. First, the parents of head-injured children in the writer's work setting are having great difficulty dealing with the changes in their child and in their family as a result of their child's injury. These parents are looking to the school for answers. Second, the writer feels that the egos of professionals, in this work setting, would not permit them to benefit from a training session run by a "parent in crisis".

Shea and Bauer (1985) stress the importance of better communication between parents and educators. They state that teachers should use clear language and avoid the interruption of defining specialized terms. This approach saves parents the embarrassment or anxiety of asking for clarification and provides them with clearer explanations and information. The use of clear language assists parents by reducing the fear and anxiety during the conference.

Although this solution sounds simple, it would be difficult to implement in the writer's work setting. Some of the staff members and therapists at the writer's school are "old timers" who are extremely resistant to change. Taking this fact into consideration, along with the fact that most of these same professionals really don't want parents involved in programming, makes this solution strategy implausible.

Nye, Westling, and Laten (1986) realize that parents often feel uncomfortable when they attend IEP meetings and have proposed parent training sessions to put parents more

at ease. They feel one way to involve parents without making them feel "embarrassed" or "stupid" is to train parents to use "cue questions" before and during their participation in IEP conferences. The cue questions used are designed to give parents confidence without appearing to challenge the "wisdom" of the professionals. The program used was developed under a grant from The U.S. Department of Education, Office of Special Education, Department of Personnel Preparation.

This solution strategy could easily be implemented within the writer's work setting. Questions could be developed to meet the needs of the special population by individual staff members. This solution strategy could be accomplished with very little cost or time to the school system.

Parent education has been found to be extremely beneficial in getting parents involved with their children's education. (Berger, 1987; Kroth, 1985; Lombana, 1983; McConkey, 1985; Shea & Bauer, 1985; Simpson, 1982; Yoshida, Fenton, Kaufman, & Maxwell, 1978). These authors argue that parents are the most important influence on their child's development. What at first appeared to be a short-lived educational fad has been shown to represent a growing need on the part of the parents. In recent years the market has been flooded with books, manuals, kits, and related materials on parent education and training. At the present time, parent education programs of all descriptions and

persuasions abound. Parent training and education programs have been found to facilitate communication between schools and parents, help remove parents from a defensive posture to a positive partnership with professionals, offer an efficient and cost-effective means of providing services to families, bring parents into the mainstream of the school, and so provides a method of encouraging their participation.

The special teacher, a front-line practitioner, is primarily responsible for parent services. Simpson (1982) suggests that just as mainstream teachers of exceptional children must learn new skills to deal with exceptional children, teachers of exceptional children must expand their skills to work with parents. He maintains that expecting anyone other than school personnel to meet the parents' educational and training needs is unrealistic, and he encourages teachers to develop appropriate programs for the parents of exceptional children in their charge.

The writer is in agreement that parent education is an excellent solution strategy to draw parents into their child's educational programming. Informed parents are more likely to become active participants in their child's educational programming. Professionals would be more likely to accept parents as equals if these parents presume to take an active and informed role.

Parent training is often initiated within the writer's work setting when educators feel that there is need or when parents request assistance. The diversity of disabilities

within the writer's school has resulted in a multitude of varied parent training and education programs to assist parents in the management of their special children. These programs have been deemed extremely successful by both the parents and professionals. Parent education, for parents of head injured children is one area that has not yet been addressed.

Description of Selection Solution

The solution to the problem of lack of parent involvement in the educational programming of their severely head injured child is based on several of the solutions strategies which were discussed earlier in this chapter. Many of the strategies contributed excellent suggestions and were be incorporated in the writer's solution strategy to solve this problem.

The strategy employed was parent education. Six sessions were presented in areas in which parents requested assistance and in problem areas as brought forth in the literature. The areas covered were as follows:

(1) Public Law 94-142
(2) Neuropsychological Assessments
(3) Cognitive Impairments
(4) Sensory and Motor Difficulties
(5) Social and Emotional Difficulties
(6) Individual Education Programs

REPORT OF ACTION TAKEN

PARENT EDUCATION - SESSION ONE

PUBLIC LAW 94-142

MARCH 7, 1988

The writer conducted a parent education session and provided parents with information and handouts on Public Law 94-142. The importance of parent involvement in in their child's educational program was stressed. The session was delivered as follows:

7:00-7:15 The writer and the parents were introduced. Coffee and cookies were served to promote parent interaction. The writer gave each parent a three ring binder with the following dividers inside;

1. PL 94-142
2. Neuro Assessment
3. Cognitive Disorders
4. Sensory & Perceptual
5. Social and Emotional
6. IEP's
7. School Forms
8. Glossary
9. Other

It was explained that by the end of the training session the notebook would be full and serve as a reference guide. Each session's handouts were of a different color to facilitate their correct placement in the notebook.

7:15-7:45 Public Law 94-142 was introduced and explained. Handouts were passed out (Appendices J, K, & L). Handouts were given out before the writer began to speak. This permitted the parents the freedom to listen and not worry about taking notes. Significant points covered included:

1. Free and appropriate education
2. Individual education program
3. Parent involvement
4. Application of the law to regular and special education teachers
5. Least restrictive environment
6. Parent notification and permission

7:45-8:15 Parents' rights and the due process procedure was discussed. Parents were given a handout outlining the procedure (Appendix M). The role of the developmental disabilities advocate was covered. The suggestion was also made to have an advocate attend the IEP meeting. A brochure from the developmental disabilities advocate's office was given.

8:15-8:35 Coffee Break

8:35-9:15 Classifications for special education were explained. Parents were given a

handout (Appendix N) on the present categories for funding in special education in accordance with P. L. 94-142. It was noted that no category presently exists for "head injuries" and that caution should be exercised in labeling the head-injured child. An Educators' Manual, published by the National Head Injury Foundation Task Force on Special Education for Students and Youths with Traumatic Head Injury (1984), was used as a point of reference.

9:15-9:30 Parent questionnaire was administered (Appendix C).

PARENT EDUCATION - SESSION TWO

NEUROPSYCHOLOGICAL ASSESSMENT

MARCH 21, 1988

The writer conducted a parent education session and provided parents with information and handouts on neuropsychological assessment. The session was delivered as follows:

7:00-7:30 Parents were welcomed, and the writer answered questions that related to the previous session on P.L. 94-142.

7:30-8:00 Neuropsychological assessment was defined, and parents were given a handout (Appendix O). The handout contained the definition, the purpose, and abilities to be assessed which included the following:

1. Thinking and reasoning
2. Memory
3. Attention and concentration
4. Ability to understand and produce written and spoken language
5. Sensory motor abilities

The difference between norm-referenced and criterion-referenced tests was discussed.

8:00-8:30 The remainder of the evening was spent introducing the major tests used at the writer's school. The actual tests

were available and sample questions were given to the parents. It was the writer's hope that if the parents saw the tests and were somewhat familiar with how they are given, it would give them a better understanding and take away the mystery.

The first test that was introduced was WISC-R. This test is the most widely used IQ test within the writer's district. Parents were given a handout (Appendix P) which contained a brief description of the test and sample questions.

8:30-8:45 Coffee Break

8:45-9:15 The Peabody Picture Vocabulary Test was introduced and explained. Parents were given a handout (Appendix Q) about the test. Once again parents were given the opportunity to take parts of the test.

9:15-9:30 The Brigance Inventory of Essential Skills was reviewed. The purpose of utilizing a criterion-referenced test in writing an educational program was discussed.

9:30-9:45 Cautions that need to be taken when interpreting norm-referenced tests

administered to head-injured children were discussed, and a handout was distributed (Appendix R). The following cautions were noted:

1. Each head-injured child is unique and has different needs.
2. Test scores may not always be an indication of the abilities of a head-injured child.
3. Caution needs to be taken not only in test selection but also in the selection of the person who is going to administer the tests.

9:45-10:00 Parent questionnaire was administered (Appendix D).

Parent Education - Session Three

Cognitive Impairments

April 4, 1988

The writer conducted a parent education session and provided parents with information and handouts on cognitive impairments. The session was delivered as follows:

7:00-7:20 Parents were welcomed, and coffee and cookies were served to promote parent interaction. The writer answered questions that related to the previous education session on neuropsychological assessments.

7:20-7:45 A glossary of special terms (Appendix S) was distributed to the parents. Session began with a discussion on cognition. Parents were given a handout (Appendix T). Information shared during this session was obtained from the latest studies on pediatric head injuries (Appendix U). Information discussed included:

1. Definition of cognition
2. Definition of cognitive rehabilitation
3. Goals of cognitive rehabilitation
4. Materials used to do cognitive rehabilitation
5. Persons qualified to provide cognitive rehabilitation
6. Determination of a child's "maximum" potential

Handouts entitled "Computer Use in Cognitive Retraining" (No. 84-023), which were purchased

from the National Head Injury Foundation, Inc. (NHIF), were distributed.

7:45-8:00 Discussion focused on memory deficits. Information shared included the following:

1. Short-term memory deficits
2. Long-term memory deficits
3. Difficulty returning to a task after interruption
4. Inconsistent memory function causing misinterpretation and confusion

8:15-8:30 Discussion focused on difficulties in organizing information. Information was shared on the following:

1. Summarizing
2. Sequencing
3. Outlining
4. Difficulty in differentiating more relevant information from less relevant information.

8:15-8:30 Coffee Break

8:30-9:00 Language and speech disorders associated with impaired cognition were discussed. Disorders discussed included the following:

1. Dysarthria
2. Receptive aphasia
3. Expressive aphasia
4. Alexia
5. Agrapia
6. Acalculia

Handouts entitled "Speech and Language Disorders" (No. 82-002), purchased from NHIF, were distributed.

9:00-9:15 Parent questionnaire was administered (Appendix E).

Parent Education - Saturday Workshop

May 21, 1988

8:00 a.m to 5:00 p.m.

Session Four - Sensory and Perceptual Motor Difficulties

8:00 a.m. to 10:15 a.m.

Session Five - Social and Emotional Difficulties

10:30 a.m. to 2:00 p.m.

Session Six - Individual Education Programs

2:15 p.m. to 5:00 p.m.

Session Four - Sensory and Perceptual Motor Difficulties

8:00 a.m. to 10:15 p.m.

The writer conducted a parent education session and provided parents with information and handouts on perceptual and sensory deficits. The session was delivered as follows:

8:00-8:30 Parents were welcomed, and coffee and donuts were served. The writer answered questions related to previous sessions.

8:30-9:00 This session began with an explanation of visual deficits. Parents received a handout on visual deficits (Appendix DD). Definitions and examples were given on the following:

1. Visual discrimination
2. Visual figure ground
3. Visual spatial difficulties
4. Visual sequencing
5. Visual motor integration

Parents were presented with a handout (Appendix V) on the Beery Developmental test of Visual Motor Integration (VMI). Parents were asked to duplicate some of the geometric forms on the test. The effects of visual deficits on school-work were discussed, and suggestions for assisting their child were given.

9:00-9:30 An explanation of auditory deficits was given, and a handout was presented (Appendix EE). The differences between the following were discussed:

1. Auditory discrimination
2. Auditory figure ground
3. Auditory sequencing
4. Auditory-visual

The effects of auditory deficits on school-work were discussed, and suggestions for assisting their child were given. A handout on the Wepman (Appendix W) was distributed. Parents were given a small portion of the test to better understand the difference between acuity and perceptual deficits.

9:30-10:00 Motor deficits, reduced motor skills, and eye-hand coordination were discussed. How these deficits interfere with classroom learning and strategies to help their child were shared.

10:00-10:15 Parent questionnaire (Appendix F) was administered.

Session Five - Social and Emotional Difficulties

10:30 a.m. to 2:00 p.m.

The writer conducted a parent education session and provided parents with information and handouts on social and emotional difficulties following head injuries. The session was delivered as follows:

10:30-12:00 A discussion centered on behavioral changes which often occur following a head injury. Examples of behaviors and suggestions for change were discussed. Behaviors discussed included the following:

1. Aggressive and inappropriate behavior
2. Lack of awareness verses denial of disability
3. Lack of self-esteem
4. Lack of initiative and planning
5. Lack of goal-directed behavior
6. Impulsivity and disinhibition
7. Self-centeredness and loss of concern for others
8. Apathy and social withdrawal

Handouts entitled " Some Symptoms and Characteristic Behavior Patterns of Those Who Have Suffered Traumatic Closed Head Injuries " (No. 84-007), which were purchased from NHIF, were distributed.

12:00-1:00 Lunch was served.

1:00-1:45 The importance of a close relationship with

their child's classroom teacher and the multidisciplinary team when programming for emotional and behavioral difficulties was emphasized. The importance of consistency of techniques between home, school and therapies was emphasized. The need for parents to keep a daily log about their child was stressed. Parents were given a handout that is distributed by the National Information Center for Handicapped Children and Youth, entitled "You Are Not Alone: For Parents When They Learn That Their Child Has A Handicap" (Appendix X).

2:00-2:15 Parent questionnaire (Appendix G) was administered.

Session Six - Individual Education Programs

2:15 p.m. to 5:00 p.m.

The writer conducted a parent education session on writing an Individual Education Program (IEP) and parent roles and responsibilities. The session was delivered as follows:

2:15-2:45 The components of an IEP were explained. Parents were given a handout (Appendix Y). Points covered were as follows:

1. Statement of current levels
2. Statement of goals
3. Statement of objectives
4. Statement of services
5. Dates of services
6. Time in regular programs
7. Justification of placement
8. Responsible individuals
9. Evaluation plan

2:45-3:00 The need for the multidisciplinary team and the parents to perform as equal members of the IEP team was stressed.

3:00-3:45 The specific IEP forms used in the writer's school were reviewed. The contents of the confidential folder, and the filing policy for the folder were discussed. The Buckley Amendment was explained, and a handout (Appendix Z) was distributed.

3:45-4:15 The importance of keeping abreast of new research and information on head injuries was discussed. A Catalog of Educational

Materials, distributed at no charge from the NHIF, was given to each parent. Handouts were given to inform parents on the following:

1. Conferences (Appendix AA)
2. Journals, Guides, and Newsletters (Appendix BB)
3. Resources, Etc. (Appendix CC)

4:15-4:45 The importance of parental involvement in every aspect of their child's education was re-emphasized. The issue of parents as advocates for their child was discussed. Parents were given information about the services provided by the Development Disabilities Advocate which is provided in every state at no charge to the parent. A pamphlet from the Developmental Disabilities Advocate Office in the writer's state was distributed.

4:45-5:00 Parent questionnaire (Appendix H) was administered.

Session Six - Individual Education Programs

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4:45-5:00 Parent questionnaire (Appendix H) was administered.

The solution used in the practicum involved six parent training sessions which were conduted by the writer. These sessions were originally scheduled to be presented over a period of 12 weeks with individual sessions to be held at intervals of two weeks. Circumstances beyond the control of the writer, however, resulted in a delay of the final three

training sessions. The final three training sessions were presented in a day-long workshop so that parents could complete the training before they had to participate in their child's IEP.

CHAPTER V

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Results

Objective one was measured by a teacher-made questionnaire entitled "Public Law 94-142". The questionnaire was made up of ten true-false and fill-in-the-blank items (Appendix C). The specific objective was that parents attending the training session would demonstrate an increased knowledge of Public Law 94-142 by responding correctly to 8 out the 10 items. All 12 parents met the objective.

Objective two was measured by a teacher-made questionnaire entitled "Neuropsychological Assessments" (Appendix D). The measure was made up of ten questions including true-false and multiple-choice items. The specific objective for the second training session was that parents would demonstrate an increased knowledge and understanding of the assessment instruments used to evaluate head-injured children by responding correctly to 8 out of the 10 items. All 12 parents met the objective.

Objective three was measured by a teacher-made questionnaire entitled "Cognitive Impairments" (Appendix E). The questionnaire required parents to match terminology to the appropriate behavior. This assessment device was designed to provide parents with practical application experience involving new terminology. The specific

objective for the third training session was that parents would demonstrate an increased knowledge and understanding of cognitive disorders of head-injured children by responding correctly to 8 out of 10 items on the questionnaire. All 11 parents met the objective.

Objective four was measured by a teacher-made questionnaire entitled "Sensory and Perceptual Motor Difficulties" (Appendix F). This questionnaire also required parents to match terminology to the appropriate behavior. The specific objective for the fourth training session was that parents would demonstrate an increased knowledge and awareness of sensory and perceptual-motor difficulties of head-injured children by responding correctly to 8 out of 10 items on the questionnaire. Seven of the 11 parents met the objective.

Objective five was measured by a teacher-made questionnaire entitled "Social and Emotional Difficulties Following Head Injury" (Appendix G). Again the questionnaire required parents to match terminology to the appropriate behavior. The specific objective of the fifth training session was that parents would demonstrate an increased knowledge and awareness of social and behavioral difficulties of head-injured children by responding correctly to 8 out of 10 items on the questionnaire. Nine of the 11 parents met the objective.

Objective six was measured by a teacher-made questionnaire entitled "Individual Education Program"

(Appendix H). The 10 item questionnaire required parents to circle the correct response. The specific objective was that parents would demonstrate an increased knowledge of the IEP process by responding correctly to 8 out of 10 items. All 11 parents met the objective. Table 1 summarized the results of the six training sessions.

Table 1. Assessment Results of Parent Training Sessions

Session	Attendance	Met Criteria	Range
1. PL-94-142	12	12	90-100
2. Assessment	12	12	80-100
3. Cognitive	11	11	80-100
4. Sensory motor	11	7	60-100
5. Social/emotional	11	9	70-100
6. IEP's	11	11	90-100

A very positive effect of the parent training was the interaction among the parents. Many parents arrived to the sessions early and remained after the formal training session adjourned to talk with one another. Parents were extremely supportive of one another. During these times veteran parents shared problems and solutions about their head-injured children. They exchanged telephone numbers to provide continuing support.

One parent did not return for the last four training sessions. Their child was sent to an out-of-state residential head injury rehabilitation center. These parents found attending further sessions to be emotionally trying and chose not to continue.

Conclusions

The results of the six parent questionnaires indicate that the parents developed a working knowledge and a better understanding of the special education system and the changes that have taken place in the head-injured child. The first, second, third, and sixth objectives were met by all parents. The fourth and fifth objectives were not met by all parents at the 80 percent criteria set by the writer. The parents, however, did demonstrate a mastery of the majority of the concepts on the questionnaires. These were new and extremely difficult concepts for parents to comprehend within a two hour training session.

The writer feels that the support network established among the parents was an extremely beneficial outcome of the training. Parents continually expressed their appreciation for having been brought together. This was the first time several of the parents had the opportunity to meet with other parents of head-injured children. Finding other parents with whom they could empathize lessened their feelings of isolation.

Comments from parents, classroom teachers, and IEP

chairpersons indicated that all parents that attended the training sessions were involved and extremely responsive during the IEP meetings. Several parents served as advocates for other parents that they had met during the training session.

Comments from other professionals at the writer's school were also extremely positive about the change in the parents' role during the IEP meetings. The outgrowth that parents were well informed and willing to ask for clarification was noted by the school personnel.

In conclusion, the goals of this practicum, appear to have been successfully attained. Parents were provided with information about the special education system which helped to ease their apprehensions about working with the multidisciplinary team. Parents also gained a better understanding of the changes that have taken place in the head-injured child.

Recommendations

The writer has several recommendations based on the results of this practicum. First, parent education should be made available on a continuing and ongoing basis to every parent of a head-injured child in the writer's school district. Second, the training sessions should be given as day-long workshops rather than a series of evening meetings. Feedback from parents indicated that this format was more convenient. Third, the writer recommends that professionals

trained in head injury rehabilitation be used as guest speakers for continuing training. This would give parents a reserve on which to draw when further information is desired.

Dissemination

The results of this practicum were shared in three ways. The first was by the submission of the practicum and its results to the writer's administration.

Secondly, the writer is a member of the Council for Exceptional Children. Results of the practicum were submitted to the members of the executive committee of the local chapter.

Thirdly, the practicum was distributed to several offices who advocate support for head injury survivors. Copies were given to both of the head injury support groups in the writer's state. A copy was also distributed to the office of the developmental disabilities advocate in the writer's state. A final copy will be submitted to the National Head Injury Foundation, Inc.

References

Berger, E. (1987). Parents as partner in education. (2nd ed.). Columbus: Bell & Howell.

Chin, P., Winn, J., & Walters, R. (1978). Two-way talking with parents of special children: A process of positive communication. St. Louis: C. V. Mosby.

Gilliam, J. E. (1979). Contributions and status rankings of educational planning committee participants. Exceptional Children, 45, 466-467.

Goldstein, S., Strickland, B., Turnbull, A., & Curry, L. (1980). An observational analysis of the IEP conference. Exceptional Children, 46, 278-286.

Goldstein, S & Turner, A. (1982). Strategies to increase parent participation in IEP conferences. Exceptional Children, 48, (4), 360-362.

Hoff, L. (1978). People in crisis. Menlo Park, California: Addison-Wesley.

Hurtzler, C. (1984). The head injured child - loss, grief, and sorrow (Report No. 84-019). Framingham, MA: National Head Injury Foundation.

Kroth, R. (1985). Communicating with parents of exceptional children: Improving parent-teacher relationships. (2nd ed.). Denver: Love.

Lombana, J. (1983). Home-school partnerships: Guidelines and strategies for educators. New York: Grune & Stratton.

Marion, R. (1981). Educators, parents and exceptional children. Rockville, MD: Aspen.

McAfee, J. & Vergason, G. (1979). Parent involvement in the process of special education: Establishing the new partnership. Focus on Exceptional Children, 11, (2), 1-15.

McConkey, R. (1985). Working with parents: A practical guide for teachers and therapists. Cambridege, MA: Brookline.

McMillan, F. & Turnbull, A. (1983). Parent involvement with special education: Respecting individual differences. Education and training of the mentally retarded, 18, 4-9.

Nye, J., Westling, K, & Laten S. (1986). Communication skills for parents. The Exceptional Parent, 6, (5), 30-36.

Morrison, G. (1978). Parent involvement in the home, school, and community. Columbus, Ohio: Merrill.

Muir-Hutchinson, L. (1987). Working with professionals. The Exceptional Parent, 17, (5), 8-12.

Polinko, P., Barin, J., Leger, E. & Bachman, K. (1985). Working with the family. In M. Ylvisaker (Ed.). Head injury rehabilitation: Children and adolescents. (pp. 91-116). San Diego: College-Hill.

Savage, R. (1985). Re-entry: The head injured student returns to school (Report No. 84-024). Framingham, MA: National Head Injury Foundation.

Schuck, J. (1979). The parent-professional partnership myth or reality? Education Unlimited, 1, 26-28.

Shea, T. & Bauer, A. (1985). Parents and teachers of exceptional students. Boston: Allyn and Bacon.

Shevin, M. (1983). Meaningful parental involvement in long-range educational planning for disabled children. Education and Training of the Mentally Retarded, 18, 17-21.

Simpson, R. (1982). Future training issues. Exceptional Education Quarterly, 3, (2), 81-88.

Smith, P. (1984). You are not alone: For parents when they learn that their child has a handicap (Report No. 84-041). Framingham, MA: National Head Injury Foundation.

Yoshida, R., Fenton, M., Kaufman, M., & Maxwell, J. (1978). Parental involvement in the special education pupil planning process: The school perspective. Exceptional Children, 44, (7), 531-33.

Ylvisaker, M. (Ed.) (1985). Head injury rehabilitation: Children and adolescents. San Diego: College-Hill.

APPENDIX A

INTERVIEW GUIDELINE

INTERVIEW GUIDELINE

1. Was your child's head injury classified as severe? YES NO

2. Is your child presently in special education? YES NO

3. How old is your child? _____

4. Do you know what the letters IEP stand for? YES NO

5. Do you attend your child's IEP conferences? SOMETIMES YES NO

6. Did you attend your child's last IEP conference? YES NO

IF NO, WHY NOT_____

_____

_____

7. Do you look forward to IEP meetings? YES NO

Reason given for answer_____

_____

_____

8. Would you like to play a more active role in your child's educational programming? YES NO

If yes, what would help to accomplish this?

_____

_____

_____

APPENDIX B

INTERVIEW RESULTS

PARENT INTERVIEW RESULTS

		YES	NO
1.	Was your child's head injury classified as severe?	28	0

		YES	NO
2.	Is your child presently in special education?	28	0

3. How old is your child?

NUMBER		
2	3	YEARS OLD
2	4	"
2	5	"
1	6	"
1	9	"
2	10	"
1	12	"
2	13	"
2	14	"
1	15	"
2	16	"
3	17	"
2	18	"
1	19	"
2	20	"
2	21	"
28	12.9	MEAN AGE

		YES	NO
4.	Do you know what the letters IEP stand for?	8	20

		SOMETIMES	YES	NO
5.	Do you attend your child's IEP conferences?	7	20	1

		YES	NO
6.	Did you attend you child's last IEP conference?	26	2

7. Do you look forward to IEP meetings?	YES	NO
	0	28

NO. OF PARENTS	REASONS
25	Stressful.
16	Don't see a purpose to be there, teachers make all the decisions.
15	Don't understand terminology.
13	Teachers are negative.
6	Don't like the school.
6	Inconvenient times.
1	Felt school hated their child.

8. Would you like to play a more active role in your child's educational programming?	YES	NO
	21	7

NO. OF PARENTS	RECOMMENDATIONS
18	Someone to help them understand the purpose.
16	To know what they are really suppose to do at an IEP meeting.
16	To be able to understand the language they speak.
15	To know more about head injuries and their long term affects.
12	To know what alternatives are available to them.
8	To understand what the test results really mean.
1	Nothing can help - felt school was against their child.

APPENDIX C

PUBLIC LAW 94-142
PARENT QUESTIONNAIRE

PUBLIC LAW 94-142

FILL IN THE BLANKS AND THE THE CORRECT ANSWER FOR TRUE-FALSE QUESTIONS.

1. Public law 94-142 states that every child will receive a _____ and appropriate public education.

2. If your child tests in the mentally handicapped range following a head injury you should allow the school to label your child mentally retarded in order to get funding for the program. TRUE OR FALSE

3. Give three examples of related services;

   1._____

   2._____

   3._____

4. An Individual Education Program is your guarantee that the needs of your child are being met. Therefore, your involvement is no longer needed. TRUE OR FALSE

5. Public Law 94-142 has a specific category for head injures. TRUE OR FALSE

6. The school can test your child without your permission. TRUE OR FALSE

7. The school may move your child from one program to another if they feel it is in the best interest of your child without your permission. TRUE OR FALSE

8. If parents disagree with the multidisciplinary team they may ask for a due process hearing. TRUE OR FALSE

9. Once your child enters special education it means that your child will never go back to regular classes. TRUE OR FALSE

10. "Least restrictive environment" refers to the degree of special education needed for your child. TRUE OR FALSE

APPENDIX D

NEUROPSYCHOLOGICAL ASSESSMENTS
PARENT QUESTIONNAIRE

NEUROPSYCHOLOGICAL ASSESSMENTS

CIRCLE THE CORRECT ANSWER.

1. A neuropsychological assessment is a series of tests which measure a child's ability to perform a wide range of tasks. TRUE OR FALSE

2. A NORM REFERENCED OR CRITERION REFERENCED test compares your child to other children.

3. When your child is tested upon return to school the results are an accurate description of your child's potential. TRUE OR FALSE.

4. Your child's first neuropsychological assessment should be used as a baseline for future assessments. TRUE OR FALSE

5. The school does not need to have a medical or social history of your child in order to plan an effective educational program. TRUE OR FALSE

6. Your child can have a normal IQ and still have learning difficulties. TRUE OR FALSE

7. A good assessment should tell what your child knows as well as what he doesn't know. TRUE OR FALSE

8. The increasing rate of survival of head-injured children has placed new demands on the field of rehabilitation. TRUE OR FALSE

9. The Wechsler Intelligence Scale for Children (WISC-R) is one of the most widely used individual tests of intellegence. TRUE OR FALSE

10. Psychologists who test head-injured children do not need specific educational training in the area of head trauma rehabilitation in order to interpret the results of the tests. TRUE OR FALSE

APPENDIX E

COGNITIVE IMPAIRMENTS
PARENT QUESTIONNAIRE

COGNITIVE IMPAIRMENTS

MATCH THE COGNITIVE IMPAIRMENT WITH THE CORRECT EXAMPLE.

a. attention deficit	b. agraphia
c. impaired judgement	d. memory
e. decreased abstraction	f. sequencing
g. inflexibility	h. anomia
i. slowed processing	j. perseveration

_____1. No matter how hard your child tries, he just can't write anymore.

_____2. Your child refers to his brush as the thing you fix your hair with.

_____3. Your child is attempting to spell his name and can't get the letters in the right order.

_____4. Your child sees a car coming down the street at a high speed and runs to the other side of the street feeling confident he can out run the car.

_____5. Your child goes to the bathroom by himself but never flushes the toilet.

_____6. Your child does not understand that 2 half gallons of milk are equal to 1 gallon unless he actually sees you pour the 2 half gallons into the one gallon container.

_____7. Your child can't complete more than two math problems before he turns his pencil into a rocket that flies around the room making rocket noises.

_____8. When your child hears a new word that he thinks is funny and continues to say the word even though you tell him to stop.

_____9. Your child becomes upset and angry when his favorite TV show is pre-empted by the President's annual budget report.

_____10. You have to tell your child three times how to turn the washing machine to permanent press.

APPENDIX F

SENSORY AND PERCEPTUAL DIFFICULTIES
PARENT QUESTIONNAIRE

SENSORY AND PERCEPTUAL MOTOR DIFFICULTIES

MATCH THE SENSORY OR MOTOR IMPAIRMENT WITH THE CORRECT EXAMPLE.

a. auditory discrimination	b. eye-hand coordination
c. impaired auditory comprehension	d. auditory spatial
e. visual discrimination	f. tactile discrimination
g. visual figure ground	h. visual spatial
i. auditory figure ground	j. motor sequencing

_____1. Your child cannot learn to square dance.

_____2. When your child sees an egg he calls it a circle.

_____3. Your child cannot understand what you are saying if the radio is on.

_____4. Your child picks up a piece of sandpaper and remarks how soft it is.

_____5. When your child constantly hits the escape key on the computer when attempting to hit the return key.

_____6. You tell your child to go turn off the radio that's on in the house and he can't locate the radio.

_____7. Your child cannot read unless you cover up all the sentences on the page with another piece of paper.

_____8. You tell your child to bring you the cheese and he replies with , "Thank you."

_____9. Your child writes a sentence and you can't tell where one word stops and the other begins.

_____10. You sing, "I left my heart in San Francisco," and your child sings, "I left my harp in Sam Clams Disco."

APPENDIX G

SOCIAL AND EMOTIONAL DIFFICULTIES
PARENT QUESTIONNAIRE

SOCIAL AND EMOTIONAL DIFFICULTIES FOLLOWING HEAD INJURY

MATCH THE BEHAVIOR TO THE APPROPRIATE EXAMPLE

a. denial	b. acting-out behavior
c. loss of self-esteem	d. lack of motivation
e. agitation	f. social withdrawal
g. self-centeredness	h. indifference
i. aggressive behavior	j. lack of goal orientated behavior

_____1. When your child constantly says that they are not as attractive as they used to be before the injury and as a result will probably never have a relationship.

_____2. When your child feels that everyone should cater to their every need because they have suffered a head injury.

_____3. When your child doesn't care about their appearance and would rather watch television than do anything else.

_____4. When your child all of a sudden does not want to to go with his friends to the concert that he has waited months to see.

_____5. When your child insists that they are going to grow up to be a surgeon despite the fact that their one hand doesn't work the way it's suppose to.

_____6. When your child continually breaks his pencils when the school work becomes difficult.

_____7. When you take your child shopping to buy a new outfit for the wedding and they refuse to make a selection and tell you to buy whatever you want.

_____8. When your child gets tired of standing in the line at the supermarket and begins to kick the person in front of them.

_____9. When your child continuously scratches his face claiming it itches all the time.

_____ 10. When your child only does what he is directed to do and won't do anything on his own.

APPENDIX H

INDIVIDUAL EDUCATION PROGRAMS
PARENT QUESTIONNAIRE

INDIVIDUAL EDUCATION PROGRAMS

FILL IN THE BLANKS OR CIRCLE THE CORRECT ANSWER.

1. You may conduct an IEP meeting with only the classroom teacher present. TRUE OR FALSE

2. Annual goals are determined by the curriculum presently being taught in your child's classroom. TRUE OR FALSE

3. All students are assigned a grade. Usually the assigned grade will be based on the child's chronological age. TRUE OR FALSE

4. Children should never be included in the IEP meeting as they don't know what is best for them. TRUE OR FALSE

5. An IEP is a legal and binding contract. TRUE OR FALSE

6. An IEP must state present levels which include both the child's strengths and weaknesses. TRUE OR FALSE

7. You do not need an IEP for related services. TRUE OR FALSE

8. If the service that your child needs is not available in the school, your child will have to do without. TRUE OR FALSE

9. A new IEP MUST be written every:

   3 months 6 months 12 months

10. The _____ amendment states that all records, files, documents and other materials which contain information directly relating to your child and which are maintained by an educational agency must be available within 45 days of a request.

APPENDIX I

BIWEEKLY LOG

Session Title_____

Successful approaches:

Unsuccessful approaches:

Were Handouts Appropriate:

Parent Comments:

APPENDIX J

PARENT HANDOUT
PUBLIC LAW 94-142

PUBLIC LAW 94-142

Public Law 94-142 (P.L. 94-142) is the Education of All Handicapped Children Act of 1975. The purpose of this law is to assure that all handicapped children have available to them a FREE APPROPRIATE PUBLIC EDUCATION and related services designed to meet their unique needs, to assure that the the rights of handicapped children and their parents or guardians are protected, to assist states and localities to provide for the education of all handicapped children, and to assess and assure the effectiveness of efforts to educate handicapped children.

1) Each child requiring special education and related services is to have an individualized education program.

2) Parents are to participate in the development, approval, and evaluation of their children's IEP. As partners with professionals in their children's education, parents have other important responsibilities and functions: to participate in assessments of their children's progress, to contribute to placement decisions, and to participate in program evaluations. In addition, parents can participate directly in the child's educational program through instruction.

3) Regular and special education teachers are to be full, participating members of the IEP decision-making team. As the professional primarily responsible for delivering services to handicapped children, teachers have a full and active role in IEP development, implementation, and evaluation.

4) Exceptional children are to be served in THE LEAST RESTRICTIVE ENVIRONMENT necessary to meet their unique educational needs. This means that they are to be placed in a setting as close to a normal school placement as feasible that does not sacrifice responsiveness to the child's needs.

*** If your school district is unable to provide the services your child needs, they may negotiate a contract for those services with an approved public or private educational agency.

APPENDIX K

PARENT HANDOUT
PUBLIC LAW 94-142 TERMINOLOGY

PUBLIC LAW 94-142 TERMINOLOGY

1) SPECIAL EDUCATION - means specially designed instruction, at NO cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

2) RELATED SERVICES - means transportation and such developmental, corrective and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in school, and parent counseling and training. (Federal Register, 23 August 1977, 42479)

3) FREE AND APPROPRIATE PUBLIC EDUCATION - means special education and related services which:

   a. are to be provided at public expense, under public supervision and direction, and without charge.

   b. meet the standards of the State Educational Agency.

   c. include an appropriate preschool, elementary and secondary school education.

   d. are provided in conformity with the IEP.

APPENDIX L

PARENT HANDOUT
NOTIFICATION AND PERMISSION

NOTIFICATION OF AND PERMISSION FROM PARENTS

Parents have specific rights under P.L. 94-142. They must be notified and permission obtained from them in the following situations:

BEFORE the child is tested to determine the extent of the child's handicap and educational needs.

BEFORE the child is placed in, transferred out, or refused a special education program.

BEFORE the child is transferred or excluded from a regular classroom, "on the grounds that he/she is an exceptional child and cannot materially benefit from education in a regular classroom."

APPENDIX M

PARENT HANDOUT
DUE PROCESS

IF PARENTS DISAGREE

If parents disagree with the placement of their child they may request a "due process" hearing from the local board of education.

> Although hearings tend to sound threatening their purpose is not to create an adversary approach between home and school interactions. They are a safeguard for the child. Parents and school personnel are the child's advocates. Both want what is best for the child.

The procedure for a hearing should be as follows:

1. The parents request the local school board of education for a hearing.
2. A hearing must be held within 15 to 30 days after the parents make the request.
3. An impartial hearing officer conducts the meeting.
4. Parents and their counsel or advocate have access to school reports, records and files related to the case.
5. Parents may have counsels and witnesses to support their position.
6. The BURDEN OF PROOF is on the local education agency.
7. The meeting is closed unless an open meeting is requested.
8. The meeting is recorded.
9. A decision should be given to the parents by registered mail within 7 days.
10. If a satisfactory solution is not reached in the hearing, the parents may appeal to the State Board of Education.

REVIEW BY THE STATE BOARD OF EDUCATION

1. A written appeal to the Commission of Education must be made within ten days (time limitations may differ from state to state).

2. The appeal requires that the State Board of Education will examine the record of the meeting and determine if the hearing procedure was in accordance with due process.

3. Oral and/or written arguments will be requested at the discretion of the State Board.

4. The Board will give their decision within 5 days after completion of the review.

5. A written notice will be sent to the parent and the local board of education.

6. Should the decision be unacceptable to the parents, it can be appealed to district court. If it is acceptable, it must be upheld by the school and parents.

APPENDIX N

PARENT HANDOUT
EDUCATIONAL FUNDING CATEGORIES

EDUCATIONAL FUNDING CATEGORIES

A major concern when a traumatically brain injured (TBI) child returns to school is what classification the child will carry. The general purpose of the present educational categories is to provide funding resources once a child becomes eligible for special education. Under P.L. 94-142 states receive funding based on the number of students in each category.

At present there is no single educational category specifically for TBI since this area was not originally recognized as a particular area of funding need. As a result these students are often placed in special educational categories which may not sufficiently meet their needs.

Of the present educational funding categories available through P.L. 94-142, the TBI student may at best fit into many handicapping categories. Caution needs to be exercised in the firm placement of TBI students into any set category. The condition implied is not necessarily the handicapping condition.

APPENDIX O

PARENT HANDOUT
WHAT IS A NEUROPSYCHOLOGICAL ASSESSMENT?

WHAT IS A NEUROPSYCHOLOGICAL ASSESSMENT

A neuropsychological assessment is a series of tests which measure a child's ability to perform a wide range of tasks. This evaluation will assess the following:

1. Thinking and reasoning abilities (both verbal and non-verbal)
2. Memory
3. Attention and concentration
4. Ability to understand and produce written and spoken language
5. Sensory motor abilities

Results of the tests are compared to groups of normal children. This allows the psychologist to compare the child to other children of the same age. These tests point out both the STRENGTHS and weaknesses of the child. The first evaluation is extremely important because it not only points out the child's strengths and weaknesses, but it serves as a baseline.

NORM-REFERENCED TEST

When a test compares a child to other children the same age, it is called a Norm-Referenced Test.

CRITERION-REFERENCED TEST

Some tests don't compare a child to other children. These tests just indicate what the child has mastered. By seeing what the child has mastered the teacher knows what to teach the child and where to begin. This type of test is called a Criterion-Referenced Test.

APPENDIX P

PARENT HANDOUT
WECHSLER INTELLIGENCE SCALE
FOR CHILDREN (REVISED)

WECHSLER INTELLIGENCE SCALES

The Wechsler Intelligence Scale for Children-Revised (WISC-R) is one of the most widely used individual tests of intelligence. Its strengths lie in the capacity to measure performance levels as well as establishing a profile of patterns of performance. The WISC-R gives three scores. It gives a verbal score, a performance score, and a full scale IQ. This test can only be administered by a professional certified in the administration of this test. Usually the school psychologist is the only person in the school certified to give this test.

Verbal subtests include:

1. Information
   EXAMPLE - Who is the President?

2. Comprehension
   EXAMPLE - What would you do if you were outside and it started to rain?

3. Arithmetic (timed) - problems must be solved without the use of paper and pencil
   EXAMPLE- Jane has one penny. Her dad gave her two pennies. Her mother gave her 2 pennies. How many does she have altogether.

4. Similarities
   EXAMPLE - How are a hat and an umbrella alike.

5. Vocabulary
   EXAMPLE - What does mortgage mean.

6. digit Span (optional subtest)
   EXAMPLE - The child is asked to repeat a series of numbers forward (5-7-3) In the second part of the test they are given numbers and asked to repeat them backwards. Examiner says 9-3-4-1) and the child must say (1-4-3-9).

Performance Subtest Include:

1. Picture Completion (timed)
   The child is presented a picture with a part missing - the child must point or tell the examiner what is missing.
   EXAMPLE - A rabbit with only one ear.

2. Picture Arrangement (timed)
   A child is given a series of pictures and must arrange them in order.
   EXAMPLE - the pictures many be a seed, a sprout, and a flower in bloom.

3. Block Design (timed)
   The child is shown a model or a picture of red and while blocks organized to make a design. The child is give the right number of blocks and must match the model presented.

4. Object Assembly (timed)
   Child is presented with puzzle pieces and asked to put the puzzle together.

5. Coding (timed)
   The child is given a code as presented in illustration A and is required to made the corresponding geometric marks under the the numbers in illustration B.

A				B				
1	2	3	4	2	1	3	2	
+	o	x	^					

6 Mazes (timed and optional)
   Child is presented with a series of mazes and is told to move from one point to another.

** Head-injured children often show significant processing and learning disorders despite normal Full Scale IQ values.

* Physically handicapped children are often given the performance test for informational purposes only. Severely physically handicapped children are only given the verbal portion of the test.

APPENDIX Q

PARENT HANDOUT
PEABODY PICTURE VOCABULARY TEST

PEABODY PICTURE VOCABULARY TEST (PPVT)

The PPVT was designed to test children between the ages of two and eighteen. It may be administered by a psychologist or by a person trained in psychological testing. The speech therapist often gives this test.

The child is presented with a series of pages, each of which contains four pictures. The examiner asks the child to point to one particular picture. For example, there may be an eagle, an elephant, a giraffe, and a spider on one page. The person giving the test would ask the child to point to the spider. If the child points to the spider, credit is given.

The score is then computed. The total number of pictures correctly identified by the child is determined and a quotient score is derived. This is often considered to be a short form of an IQ test. This test usually takes about 15 minutes to give.

Lack of success on this test may be due to:

1. Poor comprehension of spoken language
2. Visual perceptual deficit
3. Lack of background vocabulary
4. Memory deficit
5. Poor auditory discrimination
6. Poor visual discrimination

APPENDIX R

PARENT HANDOUT
CAUTIONS IN ASSESSING SEVERELY
HEAD-INJURED CHILDREN

CAUTIONS IN ASSESSING SEVERELY HEAD-INJURED CHILDREN

Each Child Has Special Needs

Each severely head-injured child has their own special needs. No two head-injuries are the same and as a result, no two recovery programs are the same. However, there are several specific guidelines for these special students.

Interpret Test Scores Carefully

Test scores on norm referenced tests, criterion referenced tests, and teacher-made tests are not always an accurate measurement of how well or how poorly a severely head-injured student is performing. While these tests offer valuable information, caution must be taken when using these tests to assign grades.

Take Caution in Selecting Tests

Caution needs to be exercised in selecting appropriate tests for these children. Caution must also be taken in selecting the professional who will administer the tests. It is often best to have a neuropsychologist who is trained in working with children who have severe head injuries.

APPENDIX S

PARENT HANDOUT
GLOSSARY OF SPECIAL TERMS

GLOSSARY OF SPECIAL TERMS

WHAT IS A HEAD INJURY?

Serious head injuries usually result in prolonged loss of consciousness or coma. While it may be brief, lasting only a few minutes, it may extend to days or weeks. As time in coma lengthens, emergence to a fully alert state can take a long time. The individual and his family face a prolonged period of rehabilitation that can extend for years. (National Head Injury Foundation)

Sidney Payne
Nova University

ability profile - a graphic representation of grade level or age level equivalents for an individual child, showing strengths and weaknesses on different ability dimensions.

abstract reasoning - the ability to understand relationships and to deal with ideas, images, and symbols which are more intangible than objects.

acalculia - loss of ability to do simple arithmetic.

accommodation - refers to the modification of schemes to incorporate new knowledge that does not fit them.

achievement test - a test designed to measure a person's knowledge, skills, and understanding in a subject matter area.

acuity - the sharpness or clarity of a sensation particularly as it relates to sight, hearing, or touch.

adaptive physical education - programs that have the same objectives as regular physical education programs but have modified activities to allow the participation of handicapped children.

adaptive behavior - exhibiting behaviors judged appropriate for an individual's age and cultural group to achieve personal independence and social responsibility. Three major aspects of these behaviors are maturation, learning, and social adjustment.

adaptive behavior scale - measures developed to assess the individual's functioning in nonacademic, nonintellectual skill areas such as social living and maturation.

adventitious deafness - severe reduction in hearing acuity due to illness or accident.

advocacy - full support for and representation of interests of another individual or group as if there were self interests, in a manner free from conflict of interest. Advocate: a person or group involved in this activity.

affective - pertaining to emotion, feeling, or attitudes. Used in special education to refer to school objectives which deal with motivation and development of self-image.

age or grade equivalent - a raw score or standard score expressed in years and months corresponding with the average score for that age group.

agnosia - the inability to obtain information through one of the modalities even though the receiving organ is functional. The term is often associated with central nervous system disorder or processing deficit. e.g,. The person hears what was said, can repeat what was said, but cannot process or understand how to follow through on what was said.

agraphia - inability to construct letters, words, or designs as in writing or drawing.

alexia - loss or inability to acquire reading skills following an illness or accident.

amnesia - lack of memory for periods of time.

anecdotal method - a means of recording and analyzing child behavior by observing and reporting, in narrative form, separate occurrences of the child's activities.

anomia - inability to find the correct word.

anoxia - oxygen level in the blood is insufficient to maintain normal functioning of tissue. The tissue of the brain is particularly susceptible to the insufficiency.

antecedent - condition or event that precedes a response and is observed to be associated with a specific occurrence. e.g., A child doesn't know an answer so he begins to cry. e.g., Not knowing the answer was the antecedent condition which resulted in the crying.

anterograde amnesia - (also called post-traumatic amnesia) the period following a head injury when the person is awake and alert but has difficulty storing or recalling information and recent events.

anticonvulsant - any medication used to control seizures.

anxiety - the experiencing of fear in the absence of objective reasons for that fear.

aphasia - a disorder of language learning: the loss of the ability to express or understand language symbols (spoken or written) as a result of some central nervous system dysfunction. It can be <u>expressive</u> or motor, in which the person can understand but cannot give back appropriate responses or it can be <u>receptive</u> or sensory in which the person cannot understand language he sees or hears.

aphonia - inability to utter vocal sounds, due to some structural or functional defect in the vocal cords.

apnea - episodic arrest of breathing.

apraxia - a brain disorder characterized by loss of ability to manipulate and use common objects and to execute planned movements.

aptitude test - a measure administered for the purpose of indicating an individual's potential ability to perform a certain type of activity or readiness to learn in a specific area. e.g., musical or mechanical aptitude.

architectural barrier - a condition of physical, manmade environmental structure which can prevent handicapped people from using the facility or moving about. When such barriers are removed, the resulting environment may be described as barrier free.

arithmetic processes - a term commonly used in referring to the basic computations of addition, subtraction, multiplication, and division.

arithmetic reasoning - the use of basic mathematical process in problem solving such as story problems and everyday life situations.

articulation - the process of executing movements of speech organs (tongue, lips, jaw, vocal folds) to enunciate speech sounds accurately.

articulation defects - indistinct or confusing speech resulting from failure or inability to produce commonly accepted speech sounds.

asphyxia - interference with circulation and oxygenation of the blood that leads to loss of consciousness and possible brain damage.

aspirated - inhaled.

aspirated pneumonia - a lung infection caused by inhaling a foreign body, such as food, into the lungs.

assessment - special diagnosis which may include mental, social, psychological, and educational evaluations, used to determine assignment to programs and services; a process employing observation, testing, and task analysis to determine an individual's STRENGTHS and WEAKNESSES for educational and social purposes.

assimilation - refers to the incorporation of new knowledge through the use of existing schemes.

associative memory - the assimilation, storage, and recall of connections between two or more words or concepts such as cat/dog, hot/cold, up/down, eat/ drink, etc.

astereognosia - inability to recognize things by touch.

asymtomatic - without symptoms.

ataxia - muscle incoordination that shows itself during a purposeful movement by irregularity and lack of precision.

athetoid - pertaining to repeated, involuntary, writhing movements, usually involving part of an arm or leg. Such movements stops during sleep.

atonic - loss of normal muscle tone.

atrophy - the wasting away of an organ or muscular portion of the body because of disease, disuse, or lack of nourishment.

attention - the capacity for selective perception, for choosing which stimuli to perceive.

attention span - the length of time an individual can concentrate on a specific subject or activity without thinking of or attending to something else.

attitude - a tendency to behave in a certain way or to experience particular feelings in various situations.

atypical - having characteristics that differ to some degree from those of the typical population.

audiogram - the graphic record of the findings of a hearing test.

audiometer - an instrument that measures hearing sensitivity and acuity.

auditory - pertains to the sense of hearing.

audiologist - the person who is trained to evaluate, diagnose, and treat hearing problems.

auditory discrimination - the ability to hear differences and similarities among and between sound. Poor discrimination can lead to problems in the use of spoken language.

auditory memory - the assimilation, storage, and recalling what has been heard.

auditory sequential memory - the ability to repeat a sequence of words or numbers. Needed for spelling.

auditory training - instruction and practice in the development and use of auditory skills.

auditory visual - referring to an established connection between what is heard and what is <u>seen</u> as in sound-letter association.

auditory vocal - referring to an established connection between what is heard and what is <u>spoken</u> as in repeating a spoken word.

augmentative communication - refers to all communication that supplements speech. Augmentative communication uses special symbols, aids, techniques and strategies to compensate for the impairment and disability patterns that are common to people with severe expressive communication disorders.

aura - a feeling or sensation (smell, flashing lights) that occurs prior to an epileptic seizure.

aversion therapy - a technique of behavior therapy in which an aversion - a deeply felt dislike or repulsion - is created for some behavior that a person wishes to eliminate.

barbiturates - a class of drugs widely used in sleeping pills and for relieving tension.

basal age - the highest level of a test on which an individual can pass all items.

baseline - beginning observations forming a basis for measurement prior to intervention or treatment. e.g., before beginning to modify a behavior you need to know how many times a day that behavior occurs.

battery - the use of several different techniques of educational and psychological evaluations.

behavior modification - the shaping of one's behavior to minimize or eliminate negative behaviors and to emphasize and reinforce positive behaviors, through control of a learning environment with a planned and systematic approach.

behavior checklist - a list of personality characteristics used in a rating. A rater is asked to check things such as intelligence, friendliness, helpfulness - that apply to a certain person. The rater can be a parent, teacher, employer, or any person having contact with that person.

bilateral - involvement of both sides of the body.

blend - a cluster of two or more consonants, e.g., br-, dr-, tr-, st-.

blindness - an acuity of 20/200 or less in the better eye following corrective lens or a restriction of the width of the visual field to an angle no greater than 20 degrees (number of degrees may vary from state to state).

body image - one's recognition of his or her body e.g., being aware of one's own posture.

borderline intelligence - a classification level of intelligence in the range of one to two standard deviations below the test mean (average score). Scores of 68 to 83 on the Stanford-Binet or 70 to 84 on the Wechsler scales are in the borderline range.

brain stem - the lower portion of the brain which connects it to the spinal column. The brain stem coordinates the body's vital functions (blood pressure, pulse, breathing). It also houses the riticular formation which controls counsciousness, drowsiness and attention.

career education - is the process of systematically coordinating all school, family and community components together to assist the child in reaching their potential for economic, social, and personal fulfillment for participation in productive work activities. Career education does not de-emphasize the fundamentals, rather it brings meaning to the existing curriculum by making the child aware of themselves and their potentials. Career education should not be confused with vocational education, which is the actual "hands-on" teaching of a particular skill for employment.

case history - an accumulation of pertinent information about an individual, such as family background, personal history, physical development, medical history, test results, anecdotal record of behavior. A good case history is a vital part of any evaluation.

casting , inhibitive - casting to prevent (inhibit) a limb from adopting an abnormal position caused by increased muscle tension.

casting, serial - the process or recasting a limb periodically, each time slightly improving the position of the limb until an optimal position is reached.

catheter - a tube used to remove fluid from a cavity. A urinary catheter is passed through the urethra into the bladder in order to withdraw urine.

ceiling - the level on a test at which a student cannot pass any of the items.

central nervous system - part of the total nervous system. It includes the brain and the spinal cord. (The nerve endings and fibers that go from the brain and spinal cord to all the parts of the body are called the peripheral nervous system.)

cephalocaudal - from head to tail. Refers to neurological development that proceeds from head to toe.

cerebellum - area of the brain concerned with coordinating voluntary movements and maintaining physical balance.

cebebrospinal fluid (CFS) - a water-like liquid made by the brain which fills the ventricles inside the brain and surrounds the brain and spinal cord to provide nurishment and protect them from shock.

chronological age (CA) - the actual numbers of years a person has lived.

circumlocution - refers to a "round-about" way of speaking when a person cannot find a specific word for an object, action, or event as in calling a <u>brush</u> "that thing that you fix you hair with."

closure - achieving a whole even though parts of the whole may be left out, especially as in visual or auditory closure. e.g., being able to identify the picture in a puzzle with a piece missing.

cognition - refers to basic mental structures that include concentration, analysis, discrimination, organization, categorization, and memory skills. These allow us to process information and are the basis for appropriate interaction with our surrounding. They are necessary for learning, reasoning, problem-solving, and applying adequate judgement. Cognition is the basis on which we make sense of the environment.

cognitive flexibility - the ability to shift one's cognitive or perceptual set.

cognitive rehabilitation - a therapeutic intervention aimed at retraining or facilitating the recovery of mental skills disrupted as a result of head injury. A cognitive rehabilitation program will address the various aspects of cognition.

cognitive style - an individual's personal technique of approaching problems involving cognition.

coma - a prolonged state of unconsciousness - there is no speech or meaningful response to external stimuli.

communication skills - refers to the many ways of transferring thought from one person to another through the commonly used media of speech, written words or bodily gestures.

compensatory strategy - refers to programs substituted for those in which handicapping conditions would interfere with satisfactory achievement. e.g. Programming a person keep a daily diary to assist them in remembering tasks to be done is a compensatory strategy.

competency based instruction - instruction directed toward the development of specific skills composing a desired competence or ability.

comprehension - processing language of varying complexity, relating the information to past experiences, acting upon it appropriately.

computer assisted instruction - a teaching technique in which a student alone at a computer terminal gets immediate feedback for answers and moves ahead at his or her own pace.

concentration - the capacity to deliberately maintain one's attention on specific stimuli, excluding others from awareness.

concept - knowledge that is not directly perceived through the senses but is the result of the manipulation of sensory impressions. Sometimes used to refer to a thought, opinion, or general idea of what something should be. It is a set of characteristics common to a class of objects: e.g., triangularity include all three-sided figures.

conditioned response - a response to a stimulus that, before learning, did not elicit that response.

confabulation- verbalization about people, places and events with no basis in reality. May be detailed and delivered with apparent confidence by the person.

congenital - present at birth.

contingency - a structured relationship between behaviors and delivery of subsequent events. A contingency contract is one in which the parties involved (e.g., teacher-student, parent-child) develop and agreement (usually written) specifying the positive or negative consequences of specific behaviors.

contracture - shortening of muscle fibers that cause decreased joint mobility.

contre-coup injury - when the brain is hit with sufficient force, causing it to "bounce" against the opposite side of the skull causing injury to both the site of impact and the part of the brain opposite the impact.

convergent thinking - orderly, logical thinking based on the assumption that there is only one correct solution to a problem.

convulsion - seizure.

corpus callosum - the bridge of white matter connecting the two cerebral hemispheres of the brain.

cortex - the gray matter that lies at the outer portion of the brain and is the primary center for motor functions, sensory discrimination, and intellectural processes. IT is sometimes referred to as the "cerebrum".

cranium - the skull; the bones of the head that are around the brain.

criterion - standard of performance used to indicate when a goal has been achieved.

criterion referenced - term describing a test designed to measure what a student has learned or not learned. Does not compare student to any one else.

crossing the midline - ability to perform tasks requiring the eyes or hand to cross the midline of the body. e.g., touching the right ear with the left hand.

CT scan (computerized tomography) - a series of x-rays of the brain at various levels to show its structure: a CT scan shows the more obvious changes such as enlarged ventricles or atrophy.

cueing - the use of prompts in teaching or initiating a response. e.g., a light touch on the chin resulting in closing the mouth.

cumpulsive - a behavior that a person feels forced to perform e.g., a need to wash the hands every ten minutes.

curriculum - a set of educational objectives (often teaching strategies, materials, and evaluative measures.

data - information about the person from test scores, checklists, family members, history, etc.

decoding - receptive habits in the language process which allow meaningful use of what is received either auditorially or visually.

decubitus - bed sore or skin ulcer.

defense mechanism - a general term describing behavior used to reduce tension and anxiety. The behavior may be aggressive, diversional, destructive, or any other form that achieves the purpose. Often, the individual's defense mechanism against admitting failure is to place the blame elsewhere.

decibel (dB) - a unit of measurement used to express sound intensity.

deficit based program - an educational program which is based a child's weaknesses (what the child CAN NOT do). This is not recommended for head injured children. Programs should be based on what the child CAN do (proficiency based program).

delusions - irrational beliefs that are maintained despite overwhelming evidence that they have no basis in reality.

depth perception - the ability to tell how far away an object is.

developmental disability - a severe, long-lasting disability which starts in childhood or early adulthood and causes substantial limitations in three or more major life activities. These activities include self-care, hearing, and speaking, learning, movement, decision making, capacity for independent living, and economic self-sufficiency.

deviate - describes a person who varies noticeably from societal norms in some personal, mental, emotional, moral, or physical characteristic.

diagnosis - resulting judgment after critical scrutiny. In special education, diagnosis is usually made by the interdisciplinary team who analyzed the cause or nature of a condition, situation, or problem.

diagnostic-prescriptive teaching - an approach to instruction of students on an individual basis, with attention to strengths and weaknesses, followed by teaching prescriptions to remediate the weaknesses and develop the strengths.

diagnostic test - a measure designed to analyze or locate an individual's specific area of weakness or strength to receive attention in future instruction.

differential diagnosis - an evaluation which attempts to distinguish between similar disorders or conditions by identifying those feature which are characteristic by only one of them.

differentiation - the ability to move specific body parts without moving or activating other body parts not used in the movement. e.g., move one finger at a time.

diffuse axonal injury - (also called white matter shearing) microscopic tears of the nerve fibers that may have a more significant impact on funtional abilities than more obviouse damage to the brain.

digraph - the phonetic combination of two letters to spell a single sound, as sh in shoe and ea in head.

diplopia - double vision.

directionality - One's ability to know the basic directions involved in the environment, such as right from left, up from down, and front from back.

disability - a physical, psychological, or neurological deviation in an individual's make-up. A disability may or may not be a handicap to an individual, depending to one's adjustment to it. The terms disability and handicap often have been considered and used synonymously, but this is not accurate, because a handicap actually refers to the effect produced by a disability.

discrimination - the ability to make judgements regarding sameness or differences among stimuli, whether visual, auditory, tactile, taste, etc. This ability is of great importance in academic work. e.g. being able to see there is a difference between the letters b and p, being able to hear the difference, and being able to write the two letters.

disinhibition - literally, the loss of inhibitions; a relatively common result of severe head injury involving the frontal lobes; may be manifested in inappropriate remarks or behaviors that the individual could previously have restrained.

disorientation - disturbance in understanding the situation one finds oneself. e.g., not knowing what day it is or not knowing where you are.

distractibility - inability to attend to a given task for more than a few seconds.

divergent thinking - thinking that goes off in many directions rather than focusing on only one solution. It is an aspect of creative thinking.

dominance - refers to the more advanced development of one side of the brain. Dominance determines which hand is used for writing, which eye is stronger, which foot is most likely to be used for kicking.

due process - a principle of law which guarentees a meaningful opportunity to protest and be heard prior to governmental action. In special education, this assures parents and handicapped children a hearing before placement or reassignment in special education.

dull normal - a term used to designate pupils who function just below average or normal in general intelligence. The more common term is slow learner.

dysarthria. - difficulty forming or articulating words. This may be caused by damage to the motor areas of the cortex or damage to the brain stem. Dysarthria may include speech that is slurred, talking extremely fast or slow, or showing improper pitch.

dysfluency - hesitations or interferences with smooth speech, (Sometimes used synonymously with the term stuttering.)

dsyfunction - absence of complete normal function; differs from paralysis in which there is a loss of function.

dyskinesia - a condition marked by motor restlessness and abnormal facial movements.

dyslexia - a severe reading disability; an impairment, usually due to central nervous system dysfunction, associated with printed symbols often resulting in seeing letters or numbers reversed.

edema - an abnormal accumulation of fluid in the tissues of the body. Edema of the brain can result in serious damage.

educable - capable of learning to a degree that exceeds mere repetition.

echolalia - the meaningless repetition of words; the repetition of a word or phrase just spoken by another person.

Education for All Handicapped Children Act of 1975 (P. L. 94-142) a federal law that has been described as a "Bill of Rights for the Handicapped" which includes many provisions and special features including free appropriate public education.

educationally handicapped - refers to children in school who have difficulties which result from either learning or behavior disorders or a combination of the two.

egocentric - the inability to accept another person's point of view.

electrocardiogram (EKG) - a "picture" of the heart action which results from a machine recording of the electrical currents originating in the heart.

electroencephalogram (EEG) - a record resulting from the use of a special machine to measure the electrical discharges of the brain. Also referred to as a brain wave test.

emotionally disturbed - a term used to define individuals who are not able to control their emotions well enough to maintain their behavior within an acceptable range.

empathy - a mental reaction in which one identifies himself or herself in a positive manner with another individual or group. This trait is often cited as being extremely important when relating to or teaching exceptional children.

encoding - a process that involves expressing ideas in symbols. An individual may encode by speech or writing. In contrast to decoding which is understanding ideas in symbols.

enuresis - bedwetting or involuntary release of urine.

epilepsy - a chronic condition of the central nervous system, characterized by periodic seizures accompanied by convulsions of the muscles and, with more severe attacks, loss of consciousness.

etiology - the study of the cause of an illness, disease, or condition.

evoked potential - essentially a specific type of EEG, involves recording the electrical responses of the brain that are provoked by specific visual, auditory or tactile stimuli; evoked potentials suggest how well nerve circuits are functioning and may be good predictors of outcome.

expressive language - the aspect of communication whereby messages are conveyed verbally, symbolically, or in writing.

eye-hand coordination - the ability of an individual to combine and coordinate functions of the eyes and hands in carryout manipulative activities involving the hands.

fading - the process of gradually removing assistance when helping an individual perform a task.

fantasy - daydreaming - often used to avoid meeting problems realistically.

fear of success - the motive to avoid success.

feedback - the direct return to the individual of the results of his or her behavior.

field of vision - the entire area one can see without shifting the gaze.

figure-ground perception - the ability to distinguish the foreground from the background. This perceptual skill can be through any sensory mode, but usually refers to visual or auditory sensations. The "figure" is that part of the perception that is at the center of the attention, the "ground" can be considered the background. e.g. A person may not be able to pick out his comb in a draw of of objects even though it is in his visual field.

fine motor - movement involving the small muscle groups. e.g., picking up a pencil requires fine motor control, raising your arm requires gross motor control.

fixed interval schedule - a reinforcement schedule in which reinforcement comes for the first response after a specified period of time.

fixed ratio schedule - a reinforcement schedule in which the person is rewarded each time he or she makes a specific number of responses.

fixation - the halting of personality growth at any particular stage.

flashbulb memory - a brief, clear memory of a moment of the past.

flexor - any muscle that flex a joint.

flight of ideas - speech in which a person can't "stick to a point." One idea leads to another in rapid succession with no continuity of thought.

fluency - uninterrupted smoothness in reading or speaking.

form perception - ability to recognize a particular geometric shape as being different from or the same as others.

fracture - a break in a bone.

free appropriate public education - one of the key requirements of P.L. 94-142.

free floating anxiety - an inability to specify the source of the fear.

free recall - an experimental technique in which a person hears a list of words read one at a time. After the last word is read, the person recalls as many words as possible.

frontal lobes - the area of the brain located at the front on both the left and right sides. This area plays a role in controlling emotions, motivation, social skills, expressive language (in an area on the left side referred to as Broca's area) and inhibition of impulses. The motor strip controlling movement and motor integration runs along the posterior (back) of the frontal lobe.

frustration tolerance - the ability to deal with frustrating events in daily life; the point at which a person can no longer control his anger and responds with inappropriate verbal outbursts or becomes aggressive.

fugue state - a condition in which a person can find themselves in a new location without any awareness of how they got there.

functional disorder - relating to disorders of a psycological nonorganic basis. e.g., a child who has no physical or organic problem but is unable to speak.

gait - the way one walks. Many brain-damaged children have what is called an "awkward gait."

galvanic skin response (GSR) - a decrease in the resistance of the skin to electrical conduction.

generalization - the ability to take information, rules, and strategies learned about one situation and apply them appropriately to other, similar situations. e.g., a person who learns to lock his wheelchair brakes in physical therapy may not lock the brakes while sitting in their room. Often referred to as transfer of learning.

Glasgow Coma Scale - an observational scale for rating the severity of injury in newly head injured patients; the items include eye opening, motor response and verbal responses; scores of 3-8 are defined as a severe injury, 9-12 as a moderate injury, and 13-15 as a mild injury; used for both assessment and prediction.

Glasgow Outcome Scale - a five-category outcome scale used primarily for research.

grand mal seizure (tonic-clonic) - a form of seizure in which there is a sudden loss of consciousness immediately followed by a generalized convulsion.

gross motor - skill involved in large muscle activity (Rolling, walking, running, throwing, jumping).

group intelligence test - any instrument, designed to measure intelligence, that can be administered to several persons at a time as opposed to being administered individually.

G-tube - a feeding tube inserted into the stomach through surgical opening; believed to be more comfortable than a nasogastric tube for patients who cannot eat by mouth for a long period of time.

gustatory - referring to taste.

handicap - the result of any condition or deviation, physical or mental that inhibits or prevents achievement or acceptance.

handicapism - a term referring to prejudice, stereotyping, and discrimination against the handicapped.

haptic - Kinesthetic and tactile feedback that a child receives through movement and touch. Includes all sensations derived from the skin receptors for contact, pressure, pain, warmth, and cold.

hard signs - measurable signs of neurological dysfunction, e.g., seizures, athetoid movements, inability to touch finger to nose, abnormal EEG.

hematoma - (subarchnoid, subdural, epidural) - a collection of blood that often has to be surgically removed to prevent further damage to the brain; the type of hematoma refers to its location in the membranes surrounding the brain.

hemianopsia - loss of vision on one side of the visual field.

hemiplegia - paralysis on one side of the body.

hemiparesis - weakness of one side of the body (or part of it) due to injury to the motor areas of the brain.

hydrocephalus - a significant accumulation of cerebral spinal fluid in and around the brain forcing expansion of the cranial structure.

hyperactive - describes behavior characterized by abnormal, excessive activity or movement. Such activity may interfere with a child's learning and cause considerable problems in managing this behavior.

hyperkinesis - excessive continual movements or motor activity.

hypertension - a condition characterized by abnormally high arterial blood pressure. An individual with hypertension may have no symptoms or may have symptoms such as headache, dizziness, or nervousness. Hypertension may lead to a stroke.

hypertonia - excessive muscle tone.

hypokinesis - lack of or absence of normal body activity.

hypotonia - less than normal muscle tone.

immediate memory - the ability to recall numbers, pictures, or words immediately following presentation. Children with immediate memory problems have difficulty learning new tasks because they cannot remember instructions.

impulsivity - a behavior of acting upon impulse without preplanning or consideration for the eventual outcome.

incoherence - a poor or illogical relationship of a person's thoughts or speech.

individualized instruction - teaching and study approaches selected specifically for adaptation to a given child's interests, needs, and abilities.

Individualized Education Program (IEP) - a component of Public Law 94-142 that requires a written plan of instruction for each child receiving special services, giving a statement of the child's present levels of educational performance, annual goals, short-term objectives, specific services needed by the child, dates when these services will begin and be in effect, and related information. The program is undertaken by a team including the parent and child when applicable.

inflexibility - the inability to adjust to everyday changes in routines, usually related to injury to the frontal lobes. Some head-injured persons may have little difficulty following a structured routine but may exhibit sudden frustration and confusion when their routine is changed.

informal tests - nonstandardized tests designed and used by professionals and nonprofessionals. e.g., teacher made tests are informal tests.

inner language - a process of integrating and organizing experiences without the use of words or other linguistic symbols. Used in the development of language and characterized by the expression or creation of sentences never heard before.

insight - a characteristic of being able to quickly grasp, apprehend, or understand a situation.

institutionalization - placement and residence within a specialized structure.

instructional objective - a precise specification of a goal which defines the behavior to be changed, the conditions under which it is to occur, and the criteria for mastery.

intelligence quotient (IQ) - the numerical figure commonly used to express level of mental development. The IQ is computed by dividing the mental age (as measured by performance on an intelligence test) by the chronological age and multiplying by 100 (MA/CA x 100 = IQ).

intelligence test - a way of measuring abilities to perceive and understand relationships and carry on abstract reasoning, as well as one's total knowledge as measured by tests like the Stanford-Binet and the Wechsler scales. It is used to determine the person's IQ.

intension tremor - a tremor that occurs only with voluntary planned (intentional) movements.

intermittent reinforcement - the reinforcement of responses by a schedule. e.g., reinforcing every third time a child gives a response.

interpersonal relations - the relationship between a person and others with whom he or she interacts, such as peer group, family, and authority figures.

intervention - modifying services, programs, and strategies to maximize the child's progress.

intracranial pressure (ICP) - a measure of pressure within the skull; it must be closely monitored following a brain injury since prolonged increases in intracranial pressure can result in more damage to the brain tissue.

intrinsic motivation - the process of facilitating or improving one's performance of a given task through incentives within the task itself; i.e., a child's interest in the task motivates him to do it.

itinerant teacher - one who travels among schools or home to teach.

Jacksonian epilepsy - a type of seizure - affecting the motor cortex causing tremors and muscle contractions of one area and rapidly spreading to other areas of the body.

judgement deficits - difficulty in forming opinions or deciding on actions. Usually related to safety. Judgement is generally based on the ability to evaluate situations using past and present information. A child with poor judgement might talk to a stranger or touch a red hot stove. Common to the head-injured.

Kinesthetic sense - a general term referring to tactile sensations and muscle movement in any part of the body. Described as a receptive feedback of information to the brain in the interest of sensorimotor coordination and planning for immediate action. Activities such as reading, writing, and speech depend tremendously on kinesthetic information.

labeling - the practice of attaching a generalized name to a handicapping condition. Although labels may entitle an individual to special services, they carry the risk of creating stigmas.

lability - unstable emotions marked by emotional highs and lows even when the environment is relatively stable.

language - any system of words or symbols that when put together form a method of communication. e.g., sign language, speech.

lateral dominance - one's preference for using either the right or left side of the body and correctly interpreting the position of sidedness of the body.

laterality - complete awareness of the two sides of the body and the ability to use each separately or both sides together.

lateralization - the establishment of functions in one hemisphere or the other.

learning - acquisition of new information determined by the extent to which an individual benefits from repetition, rehearsal, or practice. Learning and memory are interdependent. If immediate memory is poor, learning will be poor because only a portion of the information will be available for rehearsal/repetition.

learning disability - one or more significant deficits in the essential learning processes of perception; conceptualization; language - written or spoken; memory; and control of attention, impulse, or motor function. These deficits may be demonstrated verbally or nonverbally. A discrepancy between expected and actual academic achievement is observable. These problems are not primarily the result of visual, hearing, or physical handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

least restrictive environment - a concept expressed by the courts in the 1970's. States that disabled persons should be educated or served in the best possible environment for each individual, and if an individual can function with less structure or restraint, he or she should have that opportunity. This led to the concept of mainstreaming.

legal blindness - level of impairmemt is 20/200 or less in the better eye after correction.

linguistics - the science or study of language and human speech, which includes the origin, structure, and semantics.

local education agency (LEA) - an administrative arrangement referred to by federal and state legislation to designate the entity responsible for providing public education through twelfth grade - usually a school district.

long term memory - the type of memory storage capable of storing a limitless amount of information indefinitely.

magnetic reasoning imaging (MRI) - (also called NMR - nuclear magnetic resonance) a new procedure that uses magnetic fields to picture the brain's soft tissue. An MRI may provide a more detailed picture than the CT scan.

mainstreaming - the concept of serving the handicapped within the regular school program, with support personnel and services, rather than placing children in self-contained special classes. This practice relates to the concept of least restrictive environment.

maladjustment - condition of being in harmony with one's environment and failure to reach satisfactory compatibility between self desires and behavior.

manuscript writing - a method of handwriting adapted from printed letter forms in which the letters are not connected. More often referred to as printing.

maturation - the process of development of a person from birth to full growth. The term may apply to physical, mental, or emotional independence.

medulla - the part of the brain stem involved in breathing, circulation, chewing, salivation, and facial movements.

memory - the function or capacity to register, retain, and retrieve information.

mental age (MA) - the level of an individual's mental ability as expressed in terms of the average chronological age of others answering the same number of items correctly on a test of mental ability. e.g., A child may have a mental age of 10 years when he is actually 13 years of age or a child may have a mental age of 10 years when he is actually 8 years of age.

mental retardation - subaverage general intellectual functioning, as measured on a standardized test, that originates during the developmental period (birth through 21) and is associated with impairment in adaptive behavior.

Mild retardation	55 to 59 IQ
Moderate retardation	40 to 54 IQ
Severe retardation	25 to 39 IQ
Profound retardation	below 25 IQ

midbrain - the part of the brain stem that contains centers for visual and auditory reflexes.

midline - the imaginary line that divides the body into right and left halves. Children who have difficulty crossing midline may have difficulty reading. Eyes must make a smooth transition from one side of the page to the other. Children with midline difficulties often start reading one line and finish reading the line above or below.

mildly handicapped - terminology applied to students with the least severe learning and behavior difficulties and who are educated in regular school programs. Usually, those with learning disabilities, behavior disorders, and/or slight mental retardation are included in this terminology.

milieu - a social setting or environment, including the effect of this environment on one's behavior. Milieu therapy is a treatment approach based on consideration of the total environment in which the person lives.

minimal brain dysfunction - term referring to children of near average, average, or above average intelligence who show learning and behavioral disorders as a result of diagnosed or suspected deviations in functions of the central nervous system. The preferred term at present is learning disability.

mirror reading - a deviancy in which images of words are thought to be seen in reverse, as in a mirror, and are read from right to left.

mirror writing - a distorted perception that causes one to write from right to left so that what is written becomes legible when read from the reflection in a mirror.

mixed dominance - a condition in which neither side of the body is consistently used. e.g., a person may use the right hand and the left foot.

mixed laterality - confusion of sidedness of the body.

mobility - the process of moving about safely and effectively within the environment.

modality - refers to the channel of learning. e.g., a deaf child's learning modality would be visual while a blind child's learning modality would be auditory.

modeling - a teaching technique in which the teacher performs a desired behavior and encourages the pupil to try the same behavior. Often the teacher will have another student model the behavior.

morpheme - the smallest linguistic unit of meaning.

morphology - the study of word formation.

motor cortex - the area of the frontal lobes involved in regulation of voluntary movements.

motor skills - any acts requiring the ability to control and direct the voluntary muscles of the body.

multidisciplinary - more than two professions represented or contributing to a common objective. e.g. A team may have a representative from physical therapy, speech therapy, occupational therapy, school psychologist, teacher, etc.

multisensory learning - an instructional technique utilizing several sense modalities for the acquisition of information (touch, hearing vision).

nasogastric tube (ng-tube) - tube that goes through the nose and throat into the stomach, typically used for feeding.

nerves - bundles of fibers which transmit impulses or messages from one part of the body to another.

neurological "soft signs" - diagnostic characteristics that are not as readily linked to brain injury as are symptoms of seizures, but are more subtle, and may be reflected in psychological and perceptual tests (e.g., coordination problems, awkward gait, etc.)

neurologically impaired or handicapped - pertaining to any of a number of conditions resulting from injury or malformation of the central nervous system. Conditions such as cerebral palsy and epilepsy are examples.

neuromotor development - concerned with the maturation of the nervous system and parallel acquisition of the central nervous system.

neuromuscular organization - in the process of maturation, the nervous system and the muscular structure of the human body begin to work together, enabling the child to accomplish movements which were impossible before. As the process continues, the child gains control over the muscles and is able to make them work for him in activities such as eating skills, walking, running, etc.

neurologist - a physician who specializes in the physiologic functions of the brain and nervous system. e.g. This doctor may run tests if seizures are suspected.

neurosurgeon - a physician who specializes in performing operations that have to do with the brain and central nervous system.

nondiscriminatory testing - administering of measures that are not prejudicial against minority groups or individuals. This is a provision of certain court cases brought because higher percentages of minority children had been placed in special classes, in which the court also ruled that children must be tested in the child's PRIMARY language and that the psychologists must develop assessment procedures that do not discriminate against minorities. The evaluation must be comprehensive, using instruments that accommodate culture, language, and adaptive factors as much as possible.

nonverbal test - test that does not require the use of words in the item or the response to it.

norm - average performance. Norms provide a basis of comparison.

norm-referenced - a term describing tests which compare an individual's performance to that of a group, in contract to criterion referenced tests, designed to measure an individual's mastery of specific content.

normalization - a principle stating that services and treatment for disabled people be provided to enabling them to reside in a manner as close as possible to what is normal in a given society, based on the individual's capabilities.

nutritionist - a person who is trained especially in the use of food for growth and general health.

paralysis - a loss of voluntary movement.

paraplegic - paralysis of the lower part of the body, including both legs.

parapnasias - use of incorrect words or word combinations.

parent involvement - term used to describe a wide range of programs. e.g., parent counseling, volunteer service, parent education, advocacy training, etc.

parietal lobe - the upper middle lobe of each side of the brain, involved in perceiving and understanding sensations, and closely linked to writing and speech fluencey.

partially sighted - a condition in which one's vision is seriously impaired, defined usually as having between 20/200 and 20/20 central visual acuity in the better eye with correction. Preferred terminology has changed to visually handicapped or impaired.

passive aggression - hostility or antagonism expressed as uncooperative, inefficient, obstructive behavior.

pathological - a diagnosed condition of the body that is indicative of disease or physical damage.

pathology - the science or branch of medicine concerned with studying diseases, their nature, causes, and treatment.

patterning - a method of training in which constantly repeated exercises are used in an effort to get other, healthy brain cells to take over the function of damaged cells.

peer - a person regarded by others as an equal in at least one pertinent respect such as age, educational level, or occupational group.

perception - awareness of one's environment through sensory stimulation. Perception is an important part of cognition and understanding.

perceptual - describes any combination of sensations automatically retained and integrated by the brain which give a person the ability to be aware of the environment.

perceptual disorders - difficulties or deficiencies in using the sense of sight, touch, smell, taste, or hearing to correctly recognize the various objects or situations within the environment.

peripheral vision - images perceived at the extreme edges of the visual field. Students with tunnel vision have no peripheral vision.

peripheral nervous system - the parts of the nervous system that are outside the brain and spinal cord.

perseveration - when one thought, verbalization, or movement is repeated over and over again, even though it is no longer appropriate.

personal orientation - general knowledge related to oneself, includes information regarding date of birth, age, name, address, etc.

PET scan (positron emitted tomography) - relatively new brain imaging procedure that allows the brain's metabolism to be pictured so that areas of greater and lesser brain activity can be discerned.

pharynx - the back of the throat.

phobia - a persistent and unreasonable fear.

phonation - the functioning of the larynx to produce vocal sounds and voice.

phoneme - one of the 36 sound families recognized in the modern English language. Spoken English contains 24 consonant phonemes and 12 vowel phonemes.

phonics - the areas of linguistics dealing with speech sounds and their relationship to symbols. As applied to reading--syllables, letter combinations, and letters that consistently represent sounds, are taught to enable the reader to be more independent in sounding out and recognizing words.

physically handicapped - describes a person with a bodily defect that interferes with education, development, or adjustment; generally refers to crippling conditions and chronic health problems but usually does not include single sensory handicaps such as blindness or deafness.

plasticity - theory stating that the function of some damaged area of the neural structures can be learned and carried out by other parts of the brain.

post traumatic amnesia - (also called anterograde amnesia) a loss of memory that occurs immediately after injury and which may continue for weeks or months. During this time patients are unable to organize or retrieve information. The length of PTA is regarded as an indicator of eventual recovery.

potential - the highest level at which a person could perform.

Premack Principle - a concept effective in reinforcing behavior whereby the child is motivated to do less desirable activities by being assured that upon completion of the activity, he will have permission to do a more desired activity. The principle operates whether or not the child is aware of the contingency. Also known as Grandma's Rule. e.g., If the child completes his math he may go out to recess.

primary reinforcer - a reinforcer that fulfills some basic need (food and drink).

procedural due process - a right to a hearing, to be notified of the hearing, to be represented by counsel, and to be given the opportunity to present evidence and confront witnesses.

proficiency based program - an educational program based on the child's strengths (what the child CAN do). This type of program is highly recommended for head injured children rather than a deficit based program.

profile - a diagram showing the scores of a person who has taken a psychological test or tests.

prognosis - a projection of outcome in the future.

program - a plan for teaching and evaluating instruction of a skill.

programmed instruction - learning materials designed to present knowledge and skills to pupils so they can learn independently. The material may be in the form of books, teaching machines, or computers.

projective tests - tests whose overall assessment depends on clinical interpretation. e.g., the ink block test.

prosody - the inflections and intonations of speech.

prosthetic device - an artificial part attached to one's body following the loss of the natural part, such as an arm.

proximal-distal - development of muscular control from the midline to extremities. e.g., a child has arm control before he has finger control.

psychiatrist - a medical doctor who specializes in the diagnosis and treatment of mental and emotional disorders.

psychoeducational - describes programs that deal with development of both the mind (mental functions) and the educational potential of the student.

psycholinguistics - commonly used in reference to programs, services, or assessment, involving a combination of psychological aspects and the study of language or speech.

psychologist - a person who is trained and certified to administer intelligence tests and who can also evaluate and treat people with emotional problems.

psychometrics - the measurement and evaluation of behavior, the aspect of behavior receiving the most attention has been intelligence.

psychomotor seizure - an epileptic seizure in which the individual appears to be conscious during the attack but behaves in unusual or bizarre way, after which he or she does not remember what happened during the episode. Some indications of psychomotor seizures may be chewing, lip smacking, ringing in the ears, abdominal pains, dizziness.

punishment - in learning theories, any event following a behavior with the result of that behavior becoming less frequent.

qualitative date - refers to the quality of the child's response behaviors and skills used to earn the score.

quantitative date - a numerical indication of the average functioning of an individual across multiple skills and domains.

quadriparesis - a weakness which involves all four limbs.

quadriplegic - paralysis of both arms and legs.

Rancho Los Amigos Cognitive Recovery Scale - an eight-level scale of cognitive recovery ranging from I - no response to VIII - purposeful, appropriate interactions with the environment; used for assessment of recovery, for communication among health care professionals and facilities, and in research; a modified version may be used with children.

rationalization - a process by which a person finds a "good" reason for some behavior or attitude to substitute for the real reason that is not acceptable to the person.

readiness - the point in a child's maturation at which he or she has developed the sensory and intellectual skills to be able to learn the task or skill involved.

reading comprehension - the ability to understand and relate the meaning of what one has read.

recall - retrieval of previously learned information.

receptive language - the aspect of communication that involves an individual's receival and comprehension of information from others.

regression - a behavioral reaction to frustration characterized by returning to an earlier, more immature form of behavior.

rehabilitation - the process of helping a nonproductive person toward restoration of the desired standard, through education and retaining.

reinforcement - a reward given to increase the probability that a particular response can occur.

related services - described by P.L. 94-142 as services which are supportive of and may or may not be part of classroom instruction, including speech therapy, audiology, physical education, occupational therapy, physical therapy, etc.

remedial reading - corrective instruction specially offered to students who are achieving in reading at a level below the achievement expected for their chronological age.

remediation (remedial procedures) - the process of correcting inappropriate behaviors or skills. Any method or exercises designed to correct deficiencies and help a student perform nearer the level expected of his or her chronological age.

remote memory - a measurement of the amount of information an individual correctly recalls from the distant past. Typically six months to a year.

resource room - a specially equipped and managed school setting where a teacher with special training assists students in some aspect of learning. Some students may go to a resource room for one hour a day while others may may stay with that teacher all day (this would be a self-contained resource room).

respite care - temporary residential services provided in foster homes where individuals spend up to two weeks to provide a period of rest or freedom for parents or guardians.

response - behavior that follows a stimulus. e.g., If a child touches a hot stove (stimulus) the child will back away from the stove (response).

retention - the maintenance of information in storage.

retrograde amnesia - loss of memory for events prior to (often immediately preceding) the injury.

reversal - in reading, an irregularity in which a reader misperceives the order of letters, resulting in a tendency to mix the order of the letters, to confuse letters with each other, or to read from right to left.

school phobia - a general fear of school or some specific aspect of school which causes a child to resist attending school.

scoliosis - a muscle weakness allowing a serious, abnormal curvature of the spine.

selective attention - the process of controlling the selection of material from sensory memory.

self-contained class - one in which pupils are assigned and taught by the same teacher throughout the school day.

self-help skills - knowledge that allows one to carry out daily living tasks without assistance or with a minimum of assistance.

sensory impairment - damage, injury or incapacity within the sense organs or central nervous system (hearing or visual impaired.

sensory stimulation - treatment consisting of stimulation of all senses designed to encourage patients who are in coma or a vegetative state to respond to the environment.

sequelae - events following or resulting from injury.

sequencing - the ability to organize information or objects according to specified rules, or the ability to arrange information or objects in a logical progressive manner. Children who have difficulties with sequencing will have difficulty with spelling.

shaping - a term associated with behavior modification referring to the reinforcement of behavior that progressively approximates the desired terminal behavior. e.g., If a child is learning to put on his shirt you don't wait until the shirt is on before giving praise, you begin with giving praise when the child puts his arm in the sleeve.

sheltered workshop - a facility that provides individuals who are not able to work in competitive employment an opportunity to work in a controlled environment at their level of functioning.

short term memory - the type of memory storage capable of retaining information for about 15 seconds. Also referred to as working memory.

shunt - a surgical passage between two blood vessels or two spaces to drain excess fluid from the brain.

sight vocabulary - words basic to formal reading consisting of those that are memorized or recognized as a whole, rather than by a blending of parts (phonics).

sign language - any form of communication by the systematic use of gestures.

slow learner - a term used to describe children who score in the range of 70 - 89 IQ.

"soft" neurological signs - refers to mild abnormalities that are more difficult to detect than the obvious gross problems, but which indicate the possibility of handicapping signs. e.g., hyperactivity, poor eye- hand coordination, awkward gait, perseveration, impulsivity, distractibility, etc.

spasticity - an abnormal increase in muscle tone, causing the muscles to resist being stretched. A person with spasticity may look "curled up", with arms held close to the chest, or appear very stiff.

speech clinician (pathologist) (therapist) - a professional person who has special training in speech improvement and corrections, cognitive retraining, and feeding and swallowing difficulties.

speech therapy - a planned program of speech improvement and corrections, cognitive retraining, and feeding and swallowing difficulties.

splinter skill - a behavior or attribute that can be performed yet is not generalized to other behaviors within the developmental pattern.

spontaneous recovery - recovery that is due to natural healing of the brain tissue; typically occurs within the first year following an injury.

standardized test - a measure that is administered and scored by uniform objective procedures and for which norms have been established so the scores of anyone completing the test can be compared to the norm.

Stanford-Binet - a widely used, individually administered test for measuring intelligence, consists of a number of different types of items arranged in ascending order of difficulty.

state educational agency (SEA) - terminology used in federal and state legislation to refer to the department in state government which has primary responsibility for public school education.

stress - pressures that threaten the ability of the personality to continue to function adequately. Stress may be either psychological (too much responsibility or interpersonal conflicts) or biological (illness, effects of drugs, fatigue).

tactile - refers to the sense of touch.

tactile defensiveness - being overly sensitive to touch, often demonstrated by withdrawal when touched.

tactile discrimination - the ability to identify and distinguish between objects solely through touch. e.g., Being able to tell the difference between a quarter and a nickel in your pocket.

task analysis - the process of identifying and sequencing the subskills that compose a given task.

team - a group of professionals who work together to diagnose and treat students.

temporal lobe - the area in the brain involved in auditory reception and processing of visual information.

temporal orientation - time perception or an awareness of time and its relationship to events.

therapeutic - describes any treatment or structuring of the environment to improve one's well-being.

time-out - a behavior modification technique of removing an individual from situation for a specific period of time.

tonic-clonic seizure - a grand mal seizure.

total communication - a system of expressive/receptive language in which manual signs and fingerspelling are combined with speech, speechreading, and listening, in the way deemed most beneficial to the language of hearing impaired children.

tracheostomy - a surgical opening in the throat to provide an airway.

transposition - the interchanging of positions of two words or of two letters or sounds in a word, or the pronunciation of a word out of context when reading aloud. e.g., Reading the "boy thin" instead of the "thin boy".

trauma - a serious wound or injury caused by shock, force or violence.

tremors - involuntary trembling or shaking in any part of the body.

triplegia - paralysis of three limbs.

tunnel vision - a defect in which the visual field is contracted to such a degree that only central visual acuity is functioning. The resulting sight is similar to the effect of looking through a tunnel.

unilateral - pertaining only to one side.

unilateral neglect - not responding to things on one side. This usually occurs on the side opposite from the location of injury (right side injury, left side neglect). Some people will only exhibit this when both sides of the body are being touched at one. In extreme cases, the person may not bathe, dress or acknowledge one side of their body.

vegetative state - a state of lessened awareness characterized by intact "vegetative" functions (breathing, sleep/wake cycle) but no meaningful response to the environment.

ventricles - four cavities in the brain which are filled with cerebrospinal fluid serving as a cushion when the brain is impacted. These cavities may enlarge when brain tissue is damaged.

visual acuity - how well one sees.

visual closure - being able to perceive wholes from seeing only parts of the whole. e.g., recognizing that a picture of part of a face represents a face or recognizing a word after seeing only part of that word.

visual discrimination - one's ability to use the sense of sight to determine whether things he or she sees are the same or different. e.g., difference between the letters E and F or the colors of yellow and orange.

visual field deficit - not perceiving information in a specific area of the visual field. Often this involves the left or right half of the visual field, but may involve a quarter of the visual field.

visual reception - the ability to obtain meaning from what one sees.

visual sequential memory - the ability to retain a sequence of visual memories.

vocational education - the actual teaching of a particular job skill. e.g., typing, data processing.

withdrawal - avoidance of facing an annoying or unpleasant situation.

word blindness - the inability to obtain meaning from printed material (words) even though visual acuity is normal.

REFERENCES

Bagnato, S. J., & Neisworth, S. T. (1981). Linking developmental assessment and curricula. Rockville, Maryland: Aspen.

Barshaw, M. L., & Perret, Y. M. (1981). Children with handicaps: A medical primer. Baltimore: Brookes.

Ching, E. B. (1986, April). Cognitive perceptual - motor skills. Head Trauma Rehabilitation: Coma to Community. Ninth Annual Conference, San Jose, CA.

Deaton, A.V. (1987). Pediatric head trauma: A guide for families. Healthcare International, Inc.

Dorlands Illustrated Medical Dictionary. (1974) (25 Ed.). Philadelphia: Saunders.

Fischer, K. W., & Lazerson, A. (1984). Human Development. New York: Freeman.

Kirk,, S.A. & Chalfant, J. C. (1984). Academic and developmental learning disabilities. Denver: Love.

Kreutzer, J., Lent, B., Coulter, S., & McNeny, R. (1986). A glossary of cognitive rehabilitation terminology. Cognitive Rehabilitation. 4 (2), 10-13.

O'Neill, P. (1986, October). Stimulation and Facilitaion. Pediatric Head Injury: Recovery and Rehabilitation. IX Annual Adaptation Symposium, Lakewood, Colorado.

Rosenthal, M. (1984). Glossary of neuropsychological terms (Report No. 84-020) Framingham, MA: National Head Injury Foundation.

Salvia, J. & Ysseldyke, J. E. (1981). Assessment in special and remedial education (2nd Ed.). Dallas: Houghton Mifflin.

Smith, C. R. (1983). Learning disabilities: The interactin of the learner, task, and setting. Boston: Little, Brown.

Stallings, L. M. (1982). Motor learning from theory to practice. St. Louis: Mosby.

Wig, E. H., & Semel, E. M. (1980). Language assessment & intervention for the learning disabled. Columbus: Merrill.

APPENDIX T

PARENT HANDOUT
WHAT IS COGNITION?

WHAT IS COGNITION?

Cognition means knowing and understanding. Cognition refers to basic mental structure that includes concentration, analysis, discrimination, organization, categorization, and memory skills. These skills allow one to process information. They provide a basis for appropriate interaction with our surroundings. They are the skills necessary for learning, reasoning, problem-solving, and applying adequate judgement.

WHAT IS COGNITIVE REHABILITATION?

A program to address deficits caused by a head injury. These deficit many result in impairment of activities of daily living, safety, judgement, and learning. Cognitive functions are at the core of all functions and independent living.

WHAT ARE THE GOALS OF COGNITIVE REHABILITATION?

To improve attention, concentration, memory, thinking and reasoning skills, lahguage, reasoning, and sensory motor abilities.

WHAT MATERIALS ARE USED TO DO COGNITIVE REHABILITATION?

Materials used are secondary to the teachers understanding and training in the areas of cognition. Materials used with one child may not be appropriate with another child.

Computers do NOT do cognitive rehabilitation. Computers are an excellent tool with the right supervision and software. Programs relying on computer-based techniques, without the continuous involvement of a teacher, will lead to very limited effectiveness.

WHO IS QUALIFIED TO PROVIDE COGNITIVE REHABILITATION?

There is no specific licensure requirements beyond that required of the individual professional providing the treatment. Special education teachers have excellent qualifications for cognitive retraining, as do speech therapists, physical therapists, occupational therapists, adaptive physical education teachers and school psychologists.

HOW IS MAXIMUM POTENTIAL DETERMINED?

By considering the level of functioning before the injury, severity of the injury, neuropsychological test results, and motivation.

APPENDIX U

PEDIATRIC HEAD INJURY BIBLIOGRAPHY

PEDIATRIC HEAD INJURY BIBLIOGRAPHY

by Sidney Payne, M.Ed.

Brink, J., Garrett, A., Hale, W., Woo-Sam, J, & Nickel, V. (1970). Recovery of motor and intellectual functions in children sustaining severe head injuries. Developmental Medicine in Child Neurology, 12, 565-571.

Brink, J. & Hoffer, M. (1978). Rehabilitation of brain injured children. Orthopedic Clinics of North America, 9, 451-454.

Brown, G., Chadwick, O., Shaffer, D., Rutter, M., & Traub, M. (1981). A prospective study of children with head injuries: III Psychiatric sequelae. Psychological Medicine, 11, 63-78.

Bruce, D., Raphaely, R., Goldberg, A., Zimmerman, R., Bilaniuk, L., Schut, L., & Kuhl, D. (1979). Pathophysiology, treatment and outcome following severe head injury in children. Child's Brain, 5, 174-191.

Bruce, D., Schut, L., Bruno, L., Wood, J., & Sutton, L. (1978). Outcome following severe head injuries in children. Journal of Neurosurgery, 48 (5), 679-688.

Chadwick, O. (1985). Psychological sequelae of head injury in children. Developmental Medicine in Child Neurology, 27, 72-75.

Chadwick, O., Rutter, M. Brown, G., Shaffer, D., & Traub, M. (1981). A prospective study of children with head injuries: II Cognitive Sequelae. Psychological Medicine, 11, 49-61.

Chadwick, O., Rutter, M., Shaffer, D. & Shrout, P. (1981). A prospective study of children with head injuries: IV Specific Cognitive Deficits. Journal of Clinical Neuropsychology, 3, 101-120.

Chadwick, O., Rutter, M., Thompson, J. & Shaffer, D. (1980). Intellectual performance and reading skills after localized head injury in childhood. Journal Psychology and Psychiatry, 22, 117-139.

Cohen, S. (1986). Educational reintegration and programming for children with head injuries. The Journal of Head Trauma Rehabilitation, 1 (4), 22-29.

Cummings, J. (1976). Emotional aspects of head trauma in children. Rehabilitation Literature, 39, 11-12.

Eiben, C., Anderson, T., Lockman, L., Matthew, D., Dryja, J., Martin, J., Burnill, C., Gottesman, N., O'Brian, P., & Wills, L. (1984). Functional outcome of closed head injury in children and young adults. Archives of Physical Medicine and Rehabilitation, 65, 168-170.

Ewing-Cobbs,L., Fletcher, J. & Levin, H. (1986). Neurobehavioral sequelae following head injury in children: educational implications. The Journal of Head Trauma Rehabilitation, 1 (4), 57-65.

Fuld, P. & Fisher, P. (1977). Recovery of intellectual ability after closed head injury. Developmental Medicine in Child Neurology, 19, 495-502.

Gayle, F. & Janesheski, J. (1986). Neuropsychological assessment of head-injured children. The Journal of Head Trauma Rehabilitation, 1 (4), 16-21.

Hahn, Y., Raimondi, A., McLone, D. & Yamanouchi, Y. (1983). Traumatic mechanism of head injury in child abuse. Child's Brain, 10, 229-241.

Hock, R. (1984). The rehabilitation of a child with a traumatic brain injury. Springfield: Thomas

Ivan, L., Choo, S., & Ventureyra, E. (1983). Head injuries in children: A two year survey. Canadian Medical Association Journal, 128, 281-284.

Jacobson, M.S., Rubenstein, E., Bohannon, W., Sondheimer, D., Cicci, R., Toner, J. Gong, E. & Heald, F. (1986). Follow-up of adolescent trauma victims: A new model of care. Pediatrics, 77 (2), 236-241.

Jaffee, K. & Hays, R. (1986). Pediatric head injury: rehabilitative medical management. The Journal of Head Trauma Rehabilitation, 1 (4), 30-40.

Jennett, B. (1972). Head injuries in children. Developmental Medicine in Child Neurology, 14, 137-147.

Johnston, R. & Mellits, E. (1980). Pediatric coma: Prognosis and outcome. Developmental Medicine in Child Neurology, 22, 3-12.

Klonoff, H., Low, M., & ClarK, C. (1977). Head injuries in children: A prospective five year follow-up. Journal of Neurology, Neurosurgery, and Psychiatry, 40, 1211-1219.

Levin, H., & Eisenberg, H. (1979). Neuropsychological impairment after closed head injuries in children and adolescents. Journal of Pediatric Psychology, 4 (4), 389-402.

Levin, H., & Eisenberg, H. (1982). Memory and intellectual ability after head injuries in children and adolescents. Neurosurgery, 11 (5), 668-673.

Levin, H. & Eisenberg, H., (1979). Neuropsychological outcome of closed head injury in children and adolescents. Child's Brain, 5, 281-292.

Mahoney, W., D'Douza, B., Haller, J., Rogers, M., Epstein, M., & Freeman, J. (1983). Pediatrics, 71 (5), 756-762.

Mayer, T., Walker, M. Shasha, I., Matlak, M. 7 Johnson, D. (1981). Effects of multiple trauma on outcome of pediatric patients with neurologic injuries. Child's Brain, 8, 189-197.

McGuire, T., & Rothenberg, M. (1986). Behavioral and psychosocial sequelae of pediatric head injury. The Journal of Head Trauma Rehabilitation, 1 (4), 1-6.

Raimondi, A. & Hirschauer, J. (1984). Head injury in the infant and toddler, Child's Brain, 11, 12-35.

Raphaely, R., Swedlow, D., Downes, J., & Bruce, D. (1980). Pediatric Clinics of North America, 27 (3), 715-727.

Richardson, F. (1963). Some effects of severe head injury. Developmental Medicine in Child Neurology, 5, 471-482.

Rimel, R., Giordani, B., Barth, J., & Boll, T. (1981). Neurosurgery, 9 (3), 221-228.

Rivara, F. & Mueller, B. (1986) The epidemiology and prevention of pediatric head injury. The Journal of Head Trauma Rehabilitation, 1 (4), 7-15.

Roberts, I. (1979). Neurological plasticity, recovery from brain insult, and child development. Advances in Child Development and Behavior, 14, 253-319.

Rutter, M. (1981). Psychological sequelae of brain damages in children. American Journal of Psychiatry, 138 (12), 1533-1544.

Rutter, M., Chadwick, O., Shaffer, D., & Brown, G. (1980). A prospective study of children with head injuries: I Design and methods. Psychological Medicine, 10, 633-645.

Savage, R. (1987). Educational issues for the head-injured adolescent and young adult. The Journal of Head Trauma Rehabilitation, 2 (1), 1-10.

Spivack, M. (1986)., Advocacy and legislative action for head-injured children and their families. The Journal of Head Trauma Rehabilitation, 1 (4), 41-47.

Stover, S. & Zeiger, H. (1976). Head injury in children and teenagers: Functional recovery correlated with duration of coma. Archives of Physical Medicine and Rehabilitation., 56, 201-205.

Winogron, H., Knights, R., & Bawden, H. (1984). Neuropsychological deficits following head injuries in children. Journal of Clinical Neuropsychology, 6 (3), 269-286.

Ylvisaker, M. (1986). Language and communication disorders following pediatric head injury. The Journal of Head Trauma Rehabilitation, 1 (4), 48-56.

Ylvisaker, M. (Ed.). (1985). Head injury rehabilitation: Children and Adolescents. San Diego: College-Hill.

APPENDIX V

PARENT HANDOUT
BEERY DEVELOPMENTAL TEST OF
VISUAL-MOTOR INTEGRATION

BEERY DEVELOPMENT TEST OF

VISUAL MOTOR INTEGRATION (VMI)

This test may be administered individually or to children in a group. Children are required to copy forms in a workbook using a pencil. Erasing is not allowed. The test is given by a psychologist or a teacher trained in this area.

The test was developed to assess how well the child is able to integrate visual perception and motor behavior. The test consists of 24 geometric forms, from simple to complex. The children are asked to copy them one at a time.

The score is given as an age equivalent score. Children who have poor visual motor intergration will have poor handwriting. This deficit may also effect reading.

APPENDIX W

PARENT HANDOUT
WEPMAN TEST OF AUDITORY DISCRIMINATION

WEPMAN TEST OF AUDITORY DISCRIMINATION

This test is given by a school psychologist or personnel specifically trained to give this test. The speech therapist often gives this test. Test is given on a one-to-one basis.

The child is verbally presented with forty matched word pairs and is asked to indicate whether or not these words are the same . There are thirty pairs of different words and ten pairs which are the same. The following are examples of the types of words presented in the Wepman:

1. bud - bug
2. wad - wag
3. caught - fought
4. bing - bing
5. skip - ship
6. mat - met
7. cast - cast
8. dap - dat
9. eight - date
10. mack - match

The words are presented to the child, and he is asked to tell if they are the same or different. The person giving the test does not allow the child to see his mouth. Often the child is asked to turn his back to the person giving the test. Sometimes this test is presented on tape.

A child's hearing may be within normal limits, but he may have an auditory discrimination problem in that he cannot perceive certain sounds. A child with auditory discrimination problems will be a very poor speller.

APPENDIX X

PARENT HANDOUT
YOU ARE NOT ALONE: FOR PARENTS
WHEN THEY LEARN THAT THEIR CHILD HAS A HANDICAP

You Are Not Alone: For Parents When They Learn That Their Child Has a Handicap

By Patty McGill Smith

If you have recently learned that your child is developmentally delayed or has a handicapping condition, which either is or is not completely defined, this message may be for you. It is written from the personal perspective of a parent who has shared this experience and all that goes with it.

When parents learn about any difficulty or problem in their child's development, this information comes as a tremendous blow. The day my child was diagnosed as having a handicap, I was devasteated—and so confused that I recall little else about those first days other than the heartbreak. Another parent described this event as a "black sack" being pulled down over her head, blocking her ability to hear, see, and think in normal ways. Another parent described the trauma as "having a knife stuck" in her heart. Perhaps these descriptions seem a bit dramatic, yet it has been my experience that they may not sufficiently describe the many emotions that flood parents' minds and hearts when they receive any bad news about their child.

Many things can be done to help a parent through this period of trauma. That is what this paper is all about. In order to talk about some of the good things that can happen to alleviate the anxiety, let us first take a look at some of the reactions that occur.

Common Reactions

On learning that their child may have a handicap, most parents react in ways that have been shared by all parents before them who have also been faced with this disappointment and with this enormous challenge. One of the first reactions is that of *denial*—"this cannot be happening to me, to my child, to our family." Denial rapidly merges with *anger*, which may be directed toward the medical personnel who were involved in providing the information about the child's problem. Anger can also color communication between husband and wife or with grandparents or significant others in the family. Early on, it seems that the anger is so intense that it touches almost anyone, because it is triggered by feelings of *grief* and inexplicable *loss* that one does not know how to explain, nor how to deal with.

Fear is another immediate response. People often fear the unknown more than they fear the known. Having the complete diagnosis and future prospects can be easier than uncertainty. In either case, however, fear of the future is a common emotion: "What is going to happen to this child when he is five years old, when he is twelve, when he is twenty-one? What is going to happen to this child when I am gone?" Then other questions arise: "Will he ever learn? Will he ever go to college? Will he or she have the capability of loving and living and laughing and doing all the things that we had planned?".

Other unknowns also inspire fear. Parents fear that the child's condition will be the very worst that it possibly could be. Over the years, I have spoken with so many parents who said that their first thoughts were totally bleak. One expects the worst. Memories return of handicapped persons one has known. Sometimes there is guilt over some slight committed years before toward a handicpped person. There is also fear of society's rejection, fears about how brothers and sisters will be affected, questions as to whether there will be any more brothers and sisters in this family, and concerns about whether the husband or wife will love this child. These fears can almost immobilize some parents.

Then there is *guilt*—guilt and concern about whether the parents themselves have caused the problem: "Did I do something to cause this? Am I being punished for having done this? Did I take care of myself when I was pregnant? Did my wife take good enough care of herself when she was pregnant?" For myself, I remember thinking that surely my daughter had slipped from the bed when she was very young and hit her head, or that perhaps one of her brothers or sisters had inadvertantly let her drop and didn't tell me. Much self-reproach and remorse can stem from questioning the causes of the handicap.

Guilt feelings may also be manifested in spiritual and religious interpretations of blame and punishment. When they cry, "Why me?", or "Why my child?", many parents are also saying, "Why has God done this to me?". How often have we raised our eyes to heaven and asked: "What did I ever do to deserve this?". One young mother said, "I feel so guilty because all my life I had never had a hardship and now God has decided to give me a hardship."

Confusion also marks this traumatic period. As a result of not fully understanding what is happening and what will happen, confusion reveals itself in sleeplessness, inability to make decisions, and mental overload. In the midst of such a trauma, information can seem garbled and distorted. You hear new words that you never heard before, terms that describe something that you cannot understand. You want to find out what it is all about, yet it seems that you cannot make sense of all the information you are receiving. Often parents are just not on the same wavelength as the person who is trying to communicate with them about their child's handicap.

Powerlessness to change what is happening is very difficult to accept. You cannot change the fact that your child is handicapped, yet parents want to feel competent and capable of handling their own life situations. It is extremely hard to be forced to rely on the judgments, opinions, and recommendations of others. Compounding the problem is that these others are often strangers with whom no bond of trust has yet been established.

Disappointment that a child is not perfect poses a threat to many parents' egos and a challenge to their value system. This jolt to previous expectations can create reluctance to accept one's child as a valuable, developing person.

Rejection is another reaction that parents experience. Rejection can be directed toward the child or toward the medical personnel or toward other family members. One of the more serious forms of rejection, and not that uncommon, is a "death wish" for the child—a feeling that many parents report at their deepest points of depression.

During this period of time when so many different feelings can flood the mind and heart, there is no way to measure how intensely a parent may experience this constellation of emotions. Not all parents go through every one of these stages, but it is important for parents to identify with all of the potentially troublesome feelings that can arise so that they will know that *they are not alone*. There are many constructive actions that you can take immediately, and there are many sources of help, communication, and reassurance.

Seek the Assistance of Another Parent

There was a parent who helped me. Twenty-two hours after my own child's diagnosis, he made a statement that I have never forgotten: "You may not realize it today, but there may come a time in your life when you will find that having a daughter with a handicap is a blessing." I can remember being puzzled by these words, which were nonetheless an invaluable gift that lit the first light of hope for me. This parent spoke of hope for the future. He assured me that there would be programs, there would be help of many kinds and from many sources. And he was the father of a retarded boy.

My first recommendation is to try to find another parent of a handicapped child, preferably one who has chosen to be a parent helper, and seek his or her assistance. All over the United States and over the world, there are Parent-Helping-Parent Programs. The National Information Center for Handicpped Children and Youth has listings of parent groups that will reach out and help you. If you cannot find your local parent organization, write to the National Information Center to get that local information.

Talk with Your Mate

Over the years, I have discovered that many parents don't communicate their feelings regarding the problems their children have. One spouse is often concerned about not being a source of strength for the other mate. The more couples can communicate at difficult times like these, the greater their collective strength.

If there are other children, talk with them, too. Be aware of their needs. If you are not emotionally capable of talking with your children or seeing to their emotional needs at this time, identify others within your family structure who can establish a special communicative bond with them. Talk with significant others in your life—your best friend, your own parents. For many people, the tempatation to close up emotionally is great at this point, but it can be so beneficial to have reliable friends and relatives who can help to carry the emotional burden.

Rely on Positive Sources in Your Life

One positive source of strength and wisdom might be your minister, priest, or rabbi. Another might be a good friend or a counselor. Go to those who have been a strength before in your life. Find the new sources that you need now.

A very fine counselor once gave me a recipe for living through a crisis: "Each morning, when you arise, recognize your powerlessness over the situation at hand, turn this problem over to God, as you understand Him, and begin your day."

Whenever your feelings are painful, you must reach out and contact someone. Call or write or get into your car and contact a real person who will talk with you and share that pain. Pain divided is not nearly so hard to bear as is pain in isolation. Sometimes professional counseling is warranted; if you feel that this might help you, do not be reluctant to seek this avenue of assistance.

Take One Day at a Time

Fears of the future can immobilize one. Living with the reality of the day which is at hand is made more manageable if we throw out the "what if's" and "what then's" of the future. Good things continue to happen each day. Take time to "smell the roses."

Learn the Terminology
When you are introduced to new terminology, you should not be hesitant to ask what it means. Whenever someone uses a word that you don't understand, stop the conversation for a minute and ask the person to explain the meaning.

Seek Information
Some parents seek virtually "tons" of information; others are not so persistent. The important thing is that you request *accurate* information. You should not be afraid to ask questions, because asking questions will be your first step in beginning to understand more about your child. Learning how to formulate questions is an art that will make life a lot easier for you in the future. A good method is to write down your questions before entering appointments or meetings, and to write down further questions as you think of them during the meeting. Get written copies of all documentation from physicians, teachers, and therapists regarding your child. It is a good idea to buy a three-ring notebook in which to save all information that is given to you. In the future there will be many uses for information that you have recorded and filed; keep it in a safe place. Again, remember always to ask for copies of evaluations, diagnostic reports, and progress reports.

Do Not Be Intimidated
Many parents feel inadequate in the presence of people from the medical or educational professions because of their credentials. Do not be intimidated by the educational backgrounds of these and other personnel who may be involved in treating or helping your child. You do not have to apologize for wanting to know what is occurring. Do not be concerned that you are being a bother or are asking too many questions. Remember, this is *your* child, and the situation has a profound effect on your life and on your child's future. Therefore, it is important that you learn as much as you can about your situation.

Do Not Be Afraid to Show Emotion
So many parents, especially dads, repress their emotions because they believe it to be a sign of weakness to let people know how badly they are feeling. The strongest fathers of handicapped children whom I know are not afraid to show their emotions. They understand that revealing feelings does not diminish one's strength.

Learn to Deal with Bitterness and Anger
Ultimately, bitterness and anger will hurt you a great deal more than they will affect those toward whom the anger is directed. It is very valuable to be able to recognize your anger and then let go of it. It is understandable that parents will be bitter and angry and disappointed to learn that their child has a serious problem. When you realize that these negative responses tend to hurt you and make you less effective with your child, you can decide to do something about them. Life is better when you are feeling positive. You will be better equipped to meet these new challenges when bitter feelings are no longer draining your energies and initiative.

Adopt a Grateful Attitude
It is hard to remain angry when one is grateful. Sometimes, when everything seems to be going wrong, it is difficult to find a cause for gratitude. However, in the scheme of things, if you look around and count your blessings, perhaps positive feelings can overtake the more negative ones.

Maintain a Positive Outlook
A positive attitude will be one of your genuinely valuable tools for dealing with problems. There is truly always a positive side to whatever is occurring. For example, when my child was found to be handicapped, one of the other things pointed out to me was that she was (and still is) a very healthy child. The fact that she has had no physical impairments has been a great blessing over the years; she has been the healthiest child I have raised.

Keep in Touch with Reality
To stay in touch with reality is to accept life the way it is. To stay in touch with reality is also to recognize that there are somethings that we can change and other things that we cannot change. The task for all of us is learning which things we can change and then to set about doing that.

Remember That Time Is on Your Side
Time heals many wounds. This does not mean that living with and raising a child who has problems will be easy, but it is fair to say that, as time passes, a great deal can be done to alleviate the problem. Therefore, time does help!

Find Programs for Your Child
Even for those living in isolated areas of our country, assistance is available to help you with whatever problems you are having. At the end of this paper, a person is listed who will help you get started in gaining the information and assistance you need. While finding programs for your handicapped child, keep in mind that programs are also available for the rest of your family, too.

Take Care of Yourself
In times of stress, each person reacts in his or her own way. A few universal recommendations may help: get sufficient rest; eat as well as you can; take time for yourself; reach out to others for emotional support.

Avoid Pity
Self-pity, the experience of pity from others, or pity for your child is actually disabling. Pity is not what is needed. Empathy, which is the ability to feel *with* another person, is the attitude to be encouraged.

Avoid Judgments
During this period, parents may become judgmental about the way people are reacting toward them or toward their child. Many people's reactions to serious problems are based on a lack of understanding, fear of knowing what to say, or fear of the unknown. Therefore, others may sometimes react inappropriately, but you need not use too much energy in being concerned over those who are not able to respond in ways that you might prefer.

Keep Daily Routines as Normal as Possible
My mother once told me, "When a problem arises and you don't know what to do, then do whatever it was that you were going to do anyway." Practicing this habit seems to produce some normalcy and consistency when life becomes hectic.

Remember That This Is Your Child
This person is your child, first and foremost. Granted, your child's development may be different from that of other children, but this does not make your child less valuable, less human, less important, or less in need of your love and parenting. Love and enjoy your child. The child comes first; the handicapping condition is second. If you can relax and take the positive steps just outlined, one at a time, you will do the best you can, your child will benefit, and you can look forward to the future with hope.

Recognize That You Are Not Alone
The feeling of isolation at the time of diagnosis is almost a universal feeling among parents. In this paper, there are many recommendations to help diminish those feelings of separateness and isolation. You can diminish these feelings by recognizing that they have been experienced by many, many others, that understanding and constructive help are available to you and your child, and that you are not alone.

Patty McGill Smith has recently moved to Washington from Omaha, Nebraska with her two youngest daughters, Marianne, age 17 and Jane, age 13. Jane, who was diagnosed at 14 months of age, has a mental handicap and epilepsy. She has been the source of inspiration for her mother's writing and her second career.

Patty's first career was at home raising seven children. The five older children are currently in five other cities of the mid-west. They are involved in careers in law, mental retardation, biology and two are in their first year of college.

The second career for Patty began as the staff coordinator of the Pilot Parents Program of the Greater Omaha Association of Retarded Citizens. This eventually became a four state center for Pilot Parents and a national resource for information about parent to parent programs.

In 1979 Patty moved to the Meyers Children's Rehabilitation Institute at the University of Nebraska Medical Center where she coordinated statewide services for parents, siblings, advocates, and professionals working with parents.

On January 16, 1984, she became Deputy Director of the National Information Center for Handicapped Children and Youth. Patty views this as a "wonderful opportunity" for a parent to serve as the link and liaison to parent organizations and groups nationwide. One of her major responsibilities will be to facilitate the exchange of as much current information and support among parents as possible. She invites parents everywhere to send information about the programs and the good things that are happening in helping parents where they live. Parents in need of assistance may write to:

Patty Smith, *Deputy Project Director*
National Information Center for Handicapped Children and Youth
1555 Wilson Boulevard, Suite 508, Rosslyn, Virginia 22209

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APPENDIX Y

PARENT HANDOUT
NINE COMPONENTS OF AN IEP

NINE COMPONENTS OF AN IEP

1. STATEMENT OF CURRENT EDUCATION LEVEL - A report must be written which describes present levels of educational performance. This includes information on the child's academic achievement, social adaptation, prevocational and vocational skill, psychomotor skills and self-help skills. Students strengths and weaknesses must be noted.

2. STATEMENT OF GOALS - Written descriptions must be included of the goals to be achieved by the end of the school year. Goals are written for ALL SERVICES provided. These goals should be written in terms of the students and should specify clearly the desired behavior.

EXAMPLE - "The student will increase his reading comprehension."

3. STATEMENT OF OBJECTIVES - Written statements must be provided of the short term instructional objectives. Objectives are to be written for ALL SERVICES provided. They must be measurable intermediate steps between the present level of performance and the annual goals.

EXAMPLE - "The student will be able to answer, in writing, the questions which follow stories in Reading is Fun with 80% accuracy.

4. STATEMENT OF SERVICES - This statement describes specifically the educational services needed by the child. These must be determined WITHOUT AVAILABILITY of those services. The statement must include a description of:

(a) all special education and related services that are needed to meet the unique needs of the child, including the type of physical education program in which the child will participate.

(b) any special instructional media and materials that are needed.

5 DATES OF SERVICES - Statements must be included about the dates special services will begin and the length of time they will be in effect. Beginning and ending dates will be entered for EACH service the child will receive.

6. TIME IN REGULAR PROGRAMS - Information must be furnished which details the extent to which a child will participate in regular education programs. Some children will be integrated in regular classes for only a few activities such as music, art, or physical education.

7. JUSTIFICATION OF PLACEMENT - A written statement must accompany the IEP which support the type of educational placement recommended for the child. Handicapped children should be placed in special classes, separate schools, or otherwise removed from their normal peers ONLY when the nature or severity of the handicap is such that education in regular classes with the use of special aids and services cannot be achieved satisfactorily. All students will be assigned a grade, usually in accordance with their chronological age.

8. RESPONSIBLE INDIVIDUALS - A list must be furnished of the names of individuals who are responsible for implementing the IEP. For some children, this list will contain only one or two names. For other children the list will be long to include specialists.

9. EVALUATION PLAN - The IEP must include statements about the objective criteria, evaluation procedures and schedules for determining whether the short term instruction objectives are being achieved.

APPENDIX Z

PARENT HANDOUT
BUCKLEY AMENDMENT

BUCKLEY AMENDMENT

The Buckley Amendment to Public Law 93-380 protects the rights and privacy of all students and parents. The law states that all records, files, documents and other materials which contain information directly relating to a student and which are maintained by an educational agency must be available within 45 days of a request.

This legislation also states that schools cannot release information or a child's records without parent consent. The amendment established parents' right of access to their child's school records and their right to challenge information in the records they deem inaccurate or inappropriate.

APPENDIX AA

PARENT HANDOUT
CONFERENCES

CONFERENCES

Braintree Annual Traumatic Head Injury Conference - multidisciplinary professional conference that occurs in October of each year near Boston. For information contact:

Annual Traumatic Head Injury Conference
Braintree Hospital
250 Pond Street
Braintree, MA 02184
(617-848-5353)

Closing the Gap Conference - primarily concerned with computer skills, hardware, and software as well as augmentative communication devices.

Closing the Gap
P.O. Box 68
Henderson, MN 56044
(612-248-3294)

The National Head Injury Foundation sponsors two annual conferences. The advantage of these conferences is that they are not strictly for professionals but are likely to be geared more specifically to the needs of the head-injured persons and their families.

The National Head Injury Foundation
333 Turnpike Road
Southboro, MA 01772
(800-444-NHIF)

Santa Clara Annual Head Trauma Rehabilitation Conference - multidisciplinary educational/scientific conference with a different theme each year. Occurs in San Jose, California, in April.

Santa Clara Valley Medical Center
751 South Bascom
Santa Jose, CA 95128
(408-299-5600)

** HEAD INJURY CONFERENCES USUALLY OFFER REDUCED RATES FOR FAMILIY MEMBERS OF THE HEAD-INJURED PERSON. INQUIRE ABOUT THIS POSSIBILITY WHEN SENDING FOR INFORMATION.

APPENDIX BB

PARENT HANDOUT
JOURNALS, GUIDES, AND NEWSLETTERS

JOURNALS, GUIDES, AND NEWSLETTERS

Closing the Gap Newsletter - publication emphasizing computer technology and applications. It is easy to read and includes many ads that may be helpful. (612-248-3294) $21/year - published by-monthly.

Closing the Gap
P.O. Box 68
Henderson, MN 56044

Cognitive Rehabilitation - a publication for head-injured individuals, their families, and the professionals working with them. $30/year - published bi-monthly.

Cognitive Rehabilitation
6555 Carrollton Avenue
Indianapolis, IN 46220

The Exceptional Parent - a publication dealing with parenting the disabled child. $16/year - 8 issues.

The Exceptional Parent
605 Commonwealth Avenue
Boston, MA 00215

The Journal of Head Trauma Rehabilitation - $60/year - published quarterly.
Winter 1986 (Vol. 1:4) Special Issue on Pediatric Head Trauma, available for $17.50.

Aspen Publishers, Inc.
1600 Research Boulevard
Rockville, MA 20850-9951

Moving Ahead - a publication of the head-injury task force of the American Congress of Rehabilitation Medicine.

Head Injury Newsletter
P.O. Box 213
Accord, MA 02018

National Head Injury Foundation Newsletter - a publication for the families of head-injured individuals.

National Head Injury Foundation
P.O. Box 567
Framingham, MA 01701

The Resource Directory: A State Guide to Disability Related Information - a guide to resources available for persons with disabilities and includes information on vocational rehabilitation, independent living resources, special education, and advocacy. $7.00.

National Rehabilitation Information Center
The Catholic University of America
4407 Eighth Street NE
Washington, D.C. 20017

APPENDIX CC

PARENT HANDOUT
RESOURCES, ETC.

RESOURCES, ETC.

A Family Guide to the Rehabilitation of the Severely Head-Injured Patient is a booklet printed for families of patients at the Brown School and is filled with information that can help all families of head injured. For a complimentary copy write to:

Brown Schools
P.O. Box 4008
Austin, Texas 78765

A catalog listing publications issued by the National Easter Seals Society in 1987 is available for persons who have disabilities and their families. For a copy send a self-addressed, stamped, business size envelope to:

Publications Catalog
National Easter Seals Society
2023 W. Ogden Avenue
Chicago, Illinois 60612

An Educator's Manual: What Educators Need to Know About Students with Traumatic Brain Injury has been prepared by the National Head Injury Foundation at a cost of $14.00. It also contains information that every parent needs to know. Cost is $14.00 and you may use your Visa or Mastercard.

National Head Injury Foundation
333 Turnpike Road
Southborough, MA 01772

Catalog of Educational Materials is also available from the National Head Injury Foundation at no charge. Send to NHIF for your free copy.

Developing Individual Education Plans for Students Who Have Suffered Traumatic Head Injury is a manual developed for educators by the Missouri Department of Elementary and Secondary Education. For further information contact:

Jean Buss, E. Consultant
Division of Special Education
P.O. Box 480
Jefferson City, Missouri 65102
Phone (314-751-0589)

Financial Aid and Disabled Students is an eight page document which covers current information for students, parents, advisors and others concerned with how students with disabilities can pay for postsecondary education and training. Available free from:

Health Resource Center
One Dupont Circle Suite 800
Washington, D.C. 20036-1193
1-800-544-3284

Pediatric Head Trauma: A Guide for Families, written by Ann V. Deaton, Ph.D.
Published by Cumberland, A Hospital for Children and Adolescents. For a complimentary copy write to:

Cumberland
Dept. of Marketing and Ad
P.O. Box 150
New Kent, Virginia 23124

APPENDIX DD

PARENT HANDOUT
VISUAL PERCEPTUAL DEFICITS

VISUAL PERCEPTUAL DEFICITS

DISCRIMINATION	Being able to see the difference. Gross - a dog from a horse a house from a garage Fine - letters b d q p shapes - circle or oval
FIGURE-GROUND	Being able to distinguish what you need to see from the background. Example - being able to distinguish the writing on the board from the board. Many students who have suffered a head injury have a visual figure-ground deficit. These students have great difficulty working in rooms that are highly decorated. The decorations can become overwhelming. These students often have to use books with enlarged print. Some have to cover everything on the page except the specific sentence that they are reading.
SPACIAL	Directionality - difficulty naming their right hand from their left hand or up from down. Laterality - an internal awareness that the body has two sides. This deficit is often visible in the child's handwriting. Students often have difficulty judging the size of the letters and as a result it is difficult to determine upper case letters from lower case letters.
SEQUENCE	The ability to remember what is seen in the correct order. The students will have difficulty spelling.

APPENDIX EE

PARENT HANDOUT
AUDITORY PERCEPTUAL DEFICITS

AUDITORY PERCEPTUAL DEFICITS

DISCRIMINATION	Being able to distinguish sounds both gross and fine. Example - gross (trumpet or whistle) fine (b-d) (bed - bet)
FIGURE-GROUND	Being able to separate sounds fr m one another. Example - listening to someone talking while the radio is on Figure - attending to someone talking Ground - radio in the background
SPACIAL	The ability to locate sounds. Example - Being able to hear sounds as they approach you or as they are going away from you. Being able to recognize if the sound is above you or below you. This is important if you a walking or a train track or crossing the street.
SEQUENCE	The ability to pick up the sequence in which sounds are made. If a child has an auditory sequencing deficit he will have difficulty spelling words phonetically. Following directions - A child with a sequencing deficit will have to be given directions one at a time.